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ABSTRACT

The study of vocational rehabilitation of the disabled and disadvantaged in the United States and Europe focuses on the extent to which workshops and rehabilitation facilities meet the needs of handicapped individuals in their adjustment to disablement and to the world of work. The study provides background information and statistics, discusses pertinent national legislation and the steps taken to implement that legislation, summarizes the vocational rehabilitation resources and facilities employed throughout the nation, and lists references consulted for each of the following European countries: United Kingdom, France, Ireland, Belgium, Netherlands, Switzerland, Austria, Yugoslavia, Norway, Denmark, Sweden, and West Germany. The study also discusses vocational rehabilitation programs in the U.S. at the Federal level, at the regional level (region 8), and in the State of Connecticut, and describes in detail 11 model programs in various States. The study closes with a discussion of conclusions and recommendations indicating that although U.S. efforts at vocational rehabilitation are more organizationally structured than those of the European countries discussed, there is still a basic deficiency in the U.S. in making rehabilitation services available to all of those in need of such services. Appended are several Federal and Connecticut laws and directives regarding vocational rehabilitation. (JR)

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VOCATIONAL REHABILITATION OF THE DISABLED AND DISADVANTAGED IN THE UNITED STATES AND EUROPE

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A COMPARATIVE STUDY OF ADMINISTRATION AND FACILITIES FOR VOCATIONAL REHABILITATION OF THE DISABLED AND DISADVANTAGED IN THE UNITED STATES AND EUROPE

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June, 1971

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FOREWORD

During fifteen years as Connecticut's State Director of Vocational Rehabilitation Services (1956-1971) the writer has been interested in the growth and development of vocational rehabilitation, internationally as well as nationally, state-federal programs.

As a participating state-side observer, it has been easy to attribute a major cause of this growth and development to the role played by the private and public sectors in the building, expansion and improvement of rehabilitation workshops and facilities. Today, the utilization of these facilities is commonplace. Our biggest problem is that of keeping them funded and making more of them available to handicapped and disadvantaged people.

For well over two decades we have read and heard of the modern and progressive rehabilitation movement in Europe. We have been especially interested in the delivery system as promulgated in federal laws through national health, social security, welfare and other programs. It seems that workshops and rehabilitation facilities make up an integral part of the system, making vocational rehabilitation more effective. We desired to study and observe the system at close range.

The study reported here would have been impossible without the financial, moral and technical assistance of many people and many organizations. Any thanks due to persons omitted is merely an oversight and does not in any way lessen his or her contribution.

A first thanks goes to Dr. James F. Garrett, Assistant Administrator, Research and Demonstrations, who saw merit in such a project several years ago; Mrs. Francis M. Griffin, Executive Secretary, Research Fellowship Award, for her advice and encouragement; and Dr. Martin E. McCavitt, Chief, Division of International Activities, for arranging the European visits and assisting with technical details. They are staff members of Social and Rehabilitation Service, Department of Health, Education, and Welfare. A special thanks to the Award Committee for the travel grant which enabled the study to be conducted.

Without the recommendation by the Honorable Dr. William J. Sanders, Commissioner of Education, State of Connecticut, that a sabbatical leave of six months be granted me by the State Board of Education, this research study would not have been possible. I am indebted to him and the Board for their faith and confidence in me.

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My wife, Marie F. Peters, Assistant Professor, Department of Child Development and Family Relations, University of Connecticut, accompanied me on my trips to Europe and served as my research associate. I am deeply indebted to her for assistance and encouragement.

Back at the shop, Joseph L. Marra, Bureau Chief, Bureau of Vocational Rehabilitation Services, Miss Mary M. Daly, my able Administrative Assistant, and our truly wonderful Administrative Secretary, Mrs. Anne K. Cosmini, kept the work of the Division of Vocational Rehabilitation moving ahead. Without their willingness to fill in for me I could not have taken the sabbatical.

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James S. Peters, II

PART I

Introduction

PART I - INTRODUCTION

A Comparative Study of Administration and Facilities for Vocational Rehabilitation of the Disabled and Disadvantaged in the United States and Europe

During the six-month period from July 1, 1971 to January 1, 1972 we investigated the delivery systems for the disabled and culturally disadvantaged of the United States and selected countries in Europe. The primary objective of the study was to determine and understand to what degree workshops and rehabilitation centers and/or facilities are meeting the needs of handicapped individuals in their adjustment to disablement and the world of work.

Vocational rehabilitation of the disabled and the disadvantaged has become over the past fifty or more years a universal humanitarian endeavor, having a salutary effect on the self and social development as well as the economy of countries where the program is instituted. Sheltered workshops, industrial workshops and rehabilitation facilities aid greatly in the vocational rehabilitation of the handicapped person, thereby increasing his degree of independency and potential for earning wages and supporting himself and family. For years the vocational rehabilitation program has served as a buffer between independent living and welfare of thousands of handicapped persons throughout the world. The need of trained manpower and the employment of trained and professional workers increases the gross national product of the country; therefore, it was timely to undertake an investigation which would also include a study of the influence which the national policies of European countries have regarding training and employment of the handicapped and make some comparison with those of our national and state government.

LS

A corollary to the primary objective was to determine the linkage between the national government and the workshops and centers in fostering policies and procedures that aided in the eventual adaptation of the individual so disabled to self, home and society.

The study was made during a sabbatical leave from the Connecticut State Department of Education. Interviews and conferences were held with governmental officials and workers in Health, Welfare, Social Security, Education, Rehabilitation, etc. in the United States and the following European countries:

1. United Kingdom
    a. England
    b. Scotland
    c. Wales
    d. Northern Ireland
2. France
3. Ireland
4. Low Countries
    a. Belgium
    b. Netherlands
5. Switzerland
6. Austria
7. Yugoslavia
8. Scandanavia
    a. Norway
    b. Denmark
    c. Sweden
9. West Germany

During this six-month period the investigator was a Research Fellow, Psychiatric Rehabilitation, School of Medicine, Department of Psychiatry, Harvard University.

The following published and unpublished information was used extensively for providing background material for Part I of this study:

1. "Rehabilitation of the Disabled in Fifty-One Countries," U.S. Department of Health, Education and Welfare, Washington, D.C., 1964
2. "Rehabilitation and Facilities of Western Europe," U.S. Department of Health, Education and Welfare, Washington, D.C., 1963
3. "Partial Agreement in the Social and Public Health Field," 13th Session, Joint Committee on the Rehabilitation and Resettlement of the Disabled, Council of Europe, 1969 (Unpublished)

PART II

Vocational Rehabilitation and Facilities

- European Countries -

UNITED KINGDOM

The United Kingdom of Great Britain comprises England, Wales, Scotland, Northern Ireland or Ulster, the Isle of Man, and the Channel Islands. It has an area of 93,898 square miles and a population (1961) of approximately 52,834,229. England is the largest and most heavily populated country of the United Kingdom. She has an area of 50,874 square miles, excluding Wales, and a population, as estimated in 1961, of 43,874,661. Scotland has a population of 5,178,490 and an area of 29,795 square miles and is the next largest in both area and population. The population of Northern Ireland is 1,425,462 and the area 5,459 square miles (14). London, in the southeast, is the principal city. London, Southampton, Bristol, Liverpool, Hull and Newcastle are its major ports. Among its principal industrial cities are Birmingham, Sheffield, Manchester and Leeds.

The economy of Great Britain is among the most highly industrialized in the world. Nearly one-half of its working population is engaged in nationalized industries, such as manufacturing, mining and construction, where unionism is very strong (7).

The number of disabled persons in Great Britain is not available for comparison. The best figure is the number of disabled persons registered at local employment exchanges under the Disabled Persons (Employment) Act of 1944 which, in April 1962, totalled 656,400. At the beginning of 1961 there were about 107,000 registered blind persons, about two-thirds of whom were under 16 or over 65 years of age. There were approximately 25,000 to 30,000 deaf and a million and a half who were hard of hearing persons.

Resources and Facilities

Rehabilitation in Great Britain is divided among a number of governmental and voluntary agencies. These agencies' services have attained a high level of effectiveness. Emphasis is on vocational rehabilitation and placement. Except for a small percentage, the disabled persons who have undergone vocational rehabilitation have obtained gainful employment in industry or sheltered workshops. The major cities are conscious of the needs of the disabled, as shown in publication (4).

Rehabilitation in Great Britain was largely the responsibility of the private agencies, working usually in collaboration with the local public authorities and some of the Government departments until World War II. Historically, the first training school for the blind was established in 1791, and in 1868 the Royal National Institute for the Blind was founded as a coordinating agency for blind welfare.

Following World War I, a Central Committee (later Council) for the Care of Cripples was organized in Great Britain with a similar organization in Northern Ireland. The Council is affiliated with the national organization of the International Society for Rehabilitation of the Disabled (ISRD). The Council's program was originally confined to the care of crippled children. The Council developed an extensive regional system of orthopedic services and later, cooperating with Government departments, it became the recognized national body dealing with crippled children and adults. By 1936, it was administering 40 special orthopedic hospitals in the British Isles, more than 20 convalescent and other homes for cripples, 400 orthopedic clinics for outpatients, and 25 institutions of various kinds for vocational training of the disabled (1). A great many services are available for handicapped youth (21). The various services and organizations arrange for holiday outings for the physically handicapped, feeling that this is a worthwhile medium (8).

It was in 1941 that the Interdepartmental Committee on the Rehabilitation and Resettlement of Disabled Persons was established under the Chairmanship of the Parliamentary Secretary to the Ministry of Labour and National Service and as a result of the Committee's recommendations, the Disabled Persons (Employment) Act of 1944 was passed. Under this Act provision was made for the Industrial Rehabilitation and Resettlement of the Disabled. Another interdepartmental committee recommended legislation which resulted in the following acts of Parliament:

1. The National Insurance Act, 1946, provided insurance benefits for disabled persons unfit to work.
2. The National Insurance Industrial Injuries Act, 1946, superseding the Workmen's Compensation Act, provided benefits and pensions for those injured or contracting a prescribed disease while at work.
3. The National Health Service Act, 1946, and the National Health Service (Scotland) Act, 1947, provided for free medical and hospital treatment for everyone, including medical rehabilitation where necessary, and the supply of surgical and other appliances.
4. The National Assistance Act, 1948, provided financial assistance for the destitute and, in addition, empowered local authorities to extend to sighted disabled persons the comprehensive welfare services and sheltered employment facilities that they had already been obliged to

provide for the blind.

5. Special education and training of handicapped children was provided for under the Education Act, 1944, and the Scottish Education Act, 1946.

6. Under the National Health Service Act, medical rehabilitation increased both in the extent of the services offered and their wide availability to everyone standing in need of them. In 1953, for instance, there were 475 hospitals in England and Wales with facilities for rehabilitation, compared with some 300 in 1948.

The mechanics of the system has a fixed pattern. Preliminary examination is usually performed by a general practitioner in the local community who assumes responsibility for treatment if the patient does not need hospitalization. It is his responsibility to call on and be ready to use the services of other members of the local team, the welfare officer, the public health nurse, the disablement resettlement officer and others. When hospitalized, a rehabilitation plan of necessary services is worked out for his specific case. This plan includes medical care, necessary surgery, occupational therapy, and the provision of needed prosthetic appliances, artificial limbs and braces, glasses, etc., and training in their use. After these services, an assessment is made of the disabled person's residual capacities and of his need for vocational training. This assessment is made by a team consisting of a rehabilitation medical officer, a medical social worker and a disablement resettlement officer of the Ministry of Labour. Outpatient clinics are provided in hospitals where the patient, if it seems advisable, may continue his remedial exercises or spend time in occupational workshops.

The Disabled Persons (Employment) Acts, 1944 and 1958, enable the Minister of Labour to make provision to enable persons handicapped by disablement to obtain employment or work on their own account suited to their age, qualifications, and experience. A disabled person is defined as: a person who, on account of injury, disease or congenital deformity, is substantially handicapped in obtaining or keeping employment, or in undertaking work on his own account, of a kind which apart from that injury, disease or deformity would be suited to his age, experience, and qualifications.

All disabled persons are invited to apply to a local office of the Ministry of Labour to have their names entered on a Register of Disabled Persons.

An experienced placement officer, specially selected and trained for the work of resettlement and known as the Disablement Resettlement Officer (DRO), is in post at each of the Ministry's local employment exchanges. Taking into account in each case the medical advice he receives about the effect of disability on working capacity and each individual's employment history, the DRO advises the disabled about the most suitable employment and helps them to find it. He can request specialized medical advice for occupational assessment by means of an industrial rehabilitation course, if this is desirable. In his attempts to find the most suitable employment for a disabled person, he is guided, as far as is practicable, by the principle that the most satisfactory form of resettlement is employment which the disabled person can take and keep on his own merits in normal competition with his fellows. He is in touch on the one hand with hospitals and doctors to insure that he is consulted at an appropriate stage of a patient's recovery, and on the other, with local employers to secure suitable vacancies. All disabled persons, whether employed or unemployed, may request his advice.

Disablement Resettlement Officers are assisted in their work by Disablement Advisory Committees composed of representatives of employers, workers, and medical and social workers under an independent chairman.

An important feature of the British rehabilitation system is the Industrial Rehabilitation Units (IRU), operated by the Ministry of Labour. Their purposes are:

(a) to restore employment confidence by providing in an industrial atmosphere and on production work, mental and physical toning-up and an opportunity for gradual adjustment to working conditions through graduated exercise in workshops, gardens, and gymnasia in order to return the vocationally handicapped to "maximum working fitness" in the shortest possible time, and (b) to give those who must seek a different occupation, guidance as to the most suitable kind of work to follow and to assist them in finding it.

There are 17 IRUs in operation throughout Great Britain with a total capacity of 1,900 places, of which 290 are residential. Arrangements can also be made where necessary, for a stay in lodgings or a hostel for persons unable to travel daily to an IRU. Each unit is under the control of a rehabilitation officer. The staff includes a doctor, an occupational psychologist, a social worker, a disablement resettlement officer, a technical adviser, and selected craftsmen in charge of the workshops and office sections. There is no set course, but each is specially planned to meet the individual need. The average length of a course is eight weeks, but it may be as short as two weeks, or last as long as the maximum of twelve weeks. All courses are free.

Residential courses of industrial rehabilitation for the blind are provided by voluntary organizations, the Ministry of Labour contributing the cost.

Free courses of vocational training and adjustment are provided for persons who need special help in order to obtain work suited to their age, experience and general qualifications; for example, those who have not been able to acquire a skilled trade or who need to change their trade later in life. Courses in nearly 40 different trades are available in the 13 Government training centers run by the Ministry of Labour. Other courses are provided at the technical colleges run by local education authorities and at private training establishments. Others, including in special cases training for semi-skilled work, may be arranged at employers' establishments. In all these courses the disabled are trained side by side with able-bodied persons who have a special need for similar training; for example, ex-members of the regular forces or employed persons with special difficulties in resettlement.

There are also additional facilities for the disabled at four residential training centers, operated by voluntary organizations with financial assistance from the Ministry of Labour. These centers are used extensively for the disabled who are unable to travel daily to a Government training center or who are in need of special care. Assistance is also given to disabled persons suitable for professional training.

The training objective of the centers is to enable the trainee, after an agreed period, to earn full wages for his occupation. Courses are mostly for skilled work and are intensive--the majority are of 6-month duration but a few last a little longer, up to 12 months according to the trade, and the period laid down for a particular course may be extended in individual cases where, for instance, the rate of progress is retarded by disability. In the Government training centers, training is organized on the basis of a 5-day week of 45 hours (including breaks). A free toolkit is provided when the trainee starts work in a trade in which it is usual for a worker to provide his own tools.

Placement in employment of disabled persons is obtained through the cooperative efforts of the disablement resettlement officers, employers and labor unions, and their representation on Disablement Advisory Committees. These committees form a link between local employment offices and local industry, and are very effective.

Employment of the disabled in the United Kingdom has been very successful. Employers of 20 or more workers are legally required to employ a quota of registered disabled persons, which is at present 3 percent of their total staff. In addition to this quota, the Minister of Labour has designated two occupations, car-park attendant and electric passenger lift attendant, which must be reserved for the registered disabled.

There are three types of organizations providing sheltered employment for disabled persons: (1) Remploy Ltd., (2) approved voluntary undertakings and (3) local authorities, either directly or an agency with approved voluntary undertakings.

These organizations provide sheltered employment in factories, in workshops or in the home for registered disabled persons who are unable to work except under sheltered conditions (6).

Reemploy Ltd. is a company formed by the Minister of Labour for the purpose of providing sheltered employment for registered disabled persons who are unlikely to obtain or keep work in open employment. In 1962, it operated some 90 factories employing about 6,500 severely disabled men and women. The location of the factories is based on the need for sheltered employment facilities in different areas and not on economic circumstances. Reemploy Ltd. produces goods for ordinary commercial sale and a large part of this output is disposed of by normal commercial means. The remainder is supplied to public bodies such as Government departments, nationalized industries, and local authorities. Employees work a 42-hour week and are paid on standard scales of wages irrespective of trade. Although productivity and sales are steadily increasing, the company operates at a loss and is subsidized at a rate of nearly £3,000,000 a year.

Following World War I, and since 1920, local authorities have been responsible for providing sheltered employment for the blind for which financial grants are available from the Ministry of Labour. In accordance with the National Assistance Act of 1948, local authorities have been empowered to extend to all substantially and permanently disabled people the same sheltered employment facilities as they provide for the blind.

Local authorities provide sheltered employment in 13 workshops, either directly or in the workshops of voluntary undertakings, and in 30 workshops for the blind. Financial grants are available to both local authorities and voluntary organizations who provide approved sheltered workshop facilities for sighted disabled persons.

There were, as of 1961, some 25 voluntary organizations operating a total of 32 sheltered workshops under the general direction of the Ministry of Labour.

There are special placement officers and services for the blind throughout the country. They are provided by local authorities or by the Royal National Institute for the Blind on their behalf or by the Ministry of Labour. About 1,300 blind persons were recorded as being unemployed, though capable and available for work, at the beginning of 1961. The remainder of blind persons in the working age groups, numbering about 27,500, were not seeking work on account of sickness or other domestic circumstances. An increasing number of blind persons is working alongside sighted workers in a variety of trades and professions. Encouragement is also being given to the introduction of more up-to-date trades in workshops for the blind, for those blind persons who need sheltered conditions of employment (9).

Financial assistance to the disabled is provided in the form of cash allowances or pensions under five statutory programs. Three of these programs are contributory; for example, the National Insurance Scheme and the National Insurance Industrial Injuries Scheme. These schemes are administered by the Ministry of Pensions and National Insurance and are provided as sickness or injury benefits, the latter in relation to injuries received at work or as a result of war. The National Assistance Scheme, administered by the National Assistance

Board, provides for grants which are determined in accordance with the needs and resources of the disabled person and his dependents.

The Ministry of Labour pays maintenance allowances to disabled men and women who are enrolled for industrial rehabilitation or for training. Maintenance allowances vary according to the trainee's age, sex and domestic circumstances, but are higher than sickness, unemployment or industrial injuries benefits, and lower than the wages expected when the disabled person is fully trained. Male trainees in Government training centers receive a training allowance somewhat greater than the maintenance allowance payable in other situations.

Voluntary agencies still play an important part and are recognised as part of the social pattern of the country. The majority of them cooperates closely with the Ministries of Health, Labour, and Education, the National Assistance Board, and local authorities throughout the country. Some interest themselves in all types of disability and all aspects of rehabilitation; others work for particular sections of the community, e.g., the blind, the deaf, the spastics or the mentally disordered. Voluntary organizations also continue to perform special services for the disabled, such as institutions for special types of the disabled, summer camps and vacation opportunities (19).

Summation

In the United Kingdom there are 234 societies working in the field of rehabilitation of the disabled. There are three major societies in the general disability field; they are as follows:

1. Central Council--concerned with welfare.
2. National Fund--concerned with research and statistics.

3. British Council for Rehabilitation of the Disabled.

The rehabilitation of the disabled is of major concern to the three societies. There are over 2,000,000 handicapped persons in England. Some 636,000 have registered for rehabilitation of some form.

Dame Georgianna Butler founded two training colleges for the handicapped, and created the British Council by bringing together labor, government, industry and the voluntary agencies working for the handicapped following World War II. The major emphases of the Council are:

1. Education-Conduction of seminars, etc.
2. Dissemination of information - publication of journal, etc.
3. Fostering of research in medical centers--rehabilitation and other problems.
4. Building of colleges for handicapped (high IQ handicapped).
    a. College in Hampshire County for handicapped youths with high IQ's who drop out of school at 16 years of age because of medical problems.
    b. A research project for the college which takes in 40 students at a time over a period of three years.
5. Preparatory training for the handicapped. Grants are given to pay students' fees.

The Disabled Persons Employment Act of 1944 and its sequels of 1946 and 1948 established the government policy for rehabilitating the handicapped. Experience has shown that the National Health Service cannot be fully implemented without the help of volunteers. Volunteers _must_ demonstrate that they are competent but they cannot do the professional jobs.

Rehabilitation Centers are, principally, of two kinds:

1. Medical Rehabilitation Center attached to a hospital with a simulated work situation where patients get industrial experience and training while still in the hospital.
2. Industrial Rehabilitation Unit where the patient goes after hospital treatment for training.

There is only one out-patient Medical Rehabilitation Unit in gear to the needs of industry. In Scotland industrial rehabilitation is accomplished through a system of Resettlement Clinics. These clinics offer a cluster of medical and other rehabilitation services to patients with employment problems. This system is used, with some modification, in Northern Ireland and Wales. There are special training officers for the blind.

The vocational rehabilitation program of the United Kingdom has made great strides over the past thirty odd years. New social and health legislation and post-war reorganization provided a great deal of impetus to the national program. Along with the many changes has come a close working relationship between the medical and the social and vocational areas of rehabilitation. The British people and their government are determined to train and place the handicapped and disadvantaged person into productive employment (9).

The Disabled Persons (Employment) Acts, 1944 and 1958, contain the following provisions:

1. Appointment of disablement resettlement officers based in local offices of the Department of Employment, whose special duty is to advise the disabled and help them to find employment. For particularly difficult cases, medical interviewing committees or resettlement clinics have been set up in many of the principal hospitals. In connection with the placing of the blind persons in employment, thirty Blind Persons' Resettlement Officer posts were created to provide a national placing service to help and advise blind persons seeking employment. Six technically qualified Blind Persons' Training Officers have also been appointed to provide essential training on the job for blind persons placed in open employment and to give advice to employers on technical questions arising in connection with the employment of the blind.
2. Registration of the disabled by the local officers of the Department of Employment.
3. Obligation for employers of twenty or more persons to employ a quota (at present 3 percent) of registered disabled persons and to submit to official inspection of their staff registers.
4. Possibility for the Secretary of State to decide that certain vacancies shall be reserved for dis-

abled persons (only two occupations have been so reserved: car park attendant and passenger electric-lift attendant).

5. Organization of industrial rehabilitation units providing mental and physical toning up after illness or accident, an opportunity for adjusting gradually to normal working conditions, and occupational assessment to determine the type of work for which the disabled person is best suited.
6. Vocational training for the disabled under the Department's training scheme.
7. Opportunities for the disabled to attend special courses to fit them for satisfactory resettlement.
8. Establishment of sheltered workshops and other employment facilities for the seriously disabled. Under this provision the Department of Employment and Productivity supplies special aid (e.g., braille micrometers and other aids for the blind) to enable disabled persons to pursue occupations from which their disabilities would otherwise have excluded them.

With a view to modernizing and improving the efficiency of workshops for the blind, the following have been established:

A national joint council to determine pay and conditions in the workshops.

Progress has also been made in the field of sheltered employment of severely disabled sighted persons by Remploy Ltd., a non-profit making company, sponsored by the Department of Employment under Section 15 of the Disabled Persons (Employment) Act of 1944.

9. Establishment of a national council and local committees to advise and assist the Secretary of State in matters relating to the employment of disabled persons.

10. The Chronically Sick and Disabled Persons Act of 1970 requires the National Advisory Council, set up under the Disabled Persons (Employment) Act, 1944, to advise the Secretary of State on the training of persons concerned with -

    (a) placing disabled persons in employment; or

    (b) training disabled persons for employment.

11. This Act also requires the Central Youth Employment Executive to include at least one person with special responsibility for the employment of young disabled persons and stresses the desirability of including on the National Youth Employment Council and the Advisory Committees on Youth Employment for Scotland and Wales one or more persons with experience of work among young disabled persons and understanding of their special needs (16).

References

1. A Record of Fifty Years' Service to the Disabled 1919-1969 by the Central Council for the Disabled. George Over Ltd., London and Rugby, 1969

2. "A Short History of the Central Council for the Disabled - 1919-1969," Central Council for the Disabled, London, SW1

3. "Better Services for the Mentally Handicapped," Dept. of Health and Social Security, Welsh Office, London, 1971

4. Chalmers, Rosalind, Birmingham for the Disabled. Birmingham Council of Social Service in Conjunction with Central Council for the Disabled, 1969

5. "Chronically Sick and Disabled Persons Act 1970," Chap. 44, Her Majesty's Stationary Office, London

6. Dolnick, Michael M., "Sheltered Workshop Programs in the Netherlands and England." U.S. Dept. of Health, Education, and Welfare, Social and Rehabilitation Service, Rehabilitation Service Administration, Washington, D.C., 1970

7. Donaldson, Peter, Guide to the British Economy - Penguin Books, Middlesex, England, 1967

8. "Entitled to a Holiday." Report on the 1970 conference on Holidays for the Physically Disabled, The Council for the Disabled, London SW1V 1 PE, 1970

9. Fitzpatrick, Thomas K., Rehabilitation Programs and Facilities of Western Europe. U.S. Department of Health, Education, and Welfare, Washington, D.C., 1963

10. "Government Training Services," Dept. of Employment and Productivity, London, 1970 (Kit)

11. Greaves, Mary, Work and Disability. British Council for Rehabilitation of the Disabled, London, W.C. 1, 1969

12. Holidays for the Physically Handicapped. Tempus Advertising Ltd., Thorn Heath, Surrey, England, 1971

13. "Industrial Rehabilitation Units," Dept. of Employment, London, 1970

14. Newman, G.B. (Editor), Daily Mail Year Book, Associated Newspapers Group Ltd., London, 1970

15. Nicoll, E.A., C.B.E., M.A., M.D.F.R.C.S., "Industrial Rehabilitation Service," Dept. of Employment and Productivity, Nov. 1970

16. "Partial Agreement in the Social and Public Health Field," Joint Committee on the Rehabilitation and Resettlement of the Disabled, The United Kingdom, 1969

17. "Rehab--British Council for Rehabilitation of the Disabled," Annual Report 1970, London

18. "Rehabilitation," Journal of the British Council for Rehabilitation of the Disabled, January-March, 1971

19. Rehabilitation of the Disabled in Fifty-One Countries, U.S. Dept. of Health, Education, and Welfare, Vocational Rehabilitation Administration, Washington, D.C., 1964

20. Scotland for the Disabled. The Scottish Tourist Board and Edinburgh Committee for the Coordination of Services for the Disabled, Edinburgh, 1969

21. Taylor, Wallace W. and Taylor, Isabelle, W., Services for Handicapped Youth in England and Wales. International Society for Rehabilitation of the Disabled, New York, 1966

22. Ibid, Special Education of Physically Handicapped Children in Western Europe. International Society for the Welfare of Cripples, New York, 1960

23. "The Disabled Persons (Employment) Acts, 1944 and 1958," Dept. of Employment and Productivity, London, 1970

FRANCE

The Republic of France has a population of over 45 million and an area of 212,660 square miles. It is one of the major industrialised countries of Europe and has a strong agricultural economy. It is rich in mineral resources such as iron ore, coal, bauxite, and lignite. France also has large oil and natural gas deposits.

France, in comparison with other industrialized countries, is a country of small diversified farms, occupying 29 percent of the employed, producing grains, wheat, rye, barley, and oats; potatoes and sugar beets; and abundant fruits, grapes, apples, pears, plums, peaches, apricots, nuts, and cherries. Both cattle raising and fishing are extensive.

The economic life of the nation is predominantly manufacturing. Chief among these are the making of chemicals, silk and cotton, textiles, perfumes, automobiles, and iron products. Petroleum production is increasing each year. France is known to have the most important vinery in the world and its wines are of high value for export. It has well-developed power stations, a consolidated national railway system and a large merchant marine.

The estimated total number of physically handicapped persons in 1954 was said to be 1,500,000.

France has a vast number of organizations and societies that are both public and private, for the care and treatment of the disabled, which have been developed over the past several decades.

Several ministries of the government carry responsibility for the same services for different categories of the disabled; for example, the Ministry of Labor and Social Security, Ministry of Health, and Veterans and Ex-Servicemen's National Ministry have responsibility for vocational retraining opportunities. The Ministry of Labor and Social Security has responsibility for administering services to insured workers disabled by work accidents. These include physical restoration, provision of appliances, as well as retraining. The Veterans and Ex-Servicemen's National Ministry has similar responsibilities for disabled veterans.

Problems of coordination of services are manifold and various efforts have been made to overcome these. In 1944, the 22 agencies, operating rehabilitation centers for the physically handicapped of diverse types, organized into the Federation des Associations de Post-Cure et de Reeducation Functionnelle et Professionnelle des Diminues Physiques, with headquarters in Paris. Its purpose was to consolidate general aims, further define the field, improve standards, promote public understanding, serve as liaison with public and Government services, represent its members at national and international meetings, and maintain contacts with professionals in other lands. This organization is now known as the Comite National Francais de Liaison pour la Readaptation des Handicapes and is a national affiliate organization of the International Society for Rehabilitation of the Disabled (ISRD). The Association Nationale des Infirmes Moteurs Cerebraux is a member of the ISRD Commission on Cerebral Palsy.

Two legislative Acts, one in 1948 and one in 1957, were enacted to provide for coordination of services to the handicapped to prevent the serious overlapping between voluntary and public agencies, and between organizations serving the various types of disablement. In

1948, an International Commission was established which clearly defined the functions of the Ministries of Labor, Health, Education, and the National Office of Social Security. This provided for smoother coordination.

A Commission for Vocational Reclassification of the Handicapped was established in each of the 90 departments of France and consisted of representatives from labor, social security, public health, veterans bureau, voluntary organizations, and from employers and employee organizations. The departmental commissions set up vocational guidance and orientation advisory groups in each department who would work closely with physicians, educators, social workers, social psychologists, and placement officers in providing assistance to the disabled in obtaining employment. Departmental commissions would also act as liaison groups with the central Interministerial Commission.

Conseil Superieur pour le Reclassement Professionel Social Travailleurs Handicapes (Central Council for the Vocational and Social Reclassification of Disabled Workers) was established by the Act of 1957, to coordinate all efforts on behalf of handicapped workers. This legislation provides for a centralized record system on each individual; the records to be kept in the offices of the departmental commissions. All agencies involved in the rehabilitation of the individual are kept informed of his progress toward employment. The Ministry of Labor, Social Security and the Ministry of Public Health maintain central offices located in Mor near Paris, for recording vocational classifications and for processing the cases of all disabled that come under their jurisdiction.

The Ministry of Public Health has the responsibility, in addition to that for organizing hospitals and medical facilities, to work with other ministries in setting standards of operations for hospitals and rehabilitation and training centers. A number of hospitals in France are autonomous centers for physical rehabilitation, handling various types of disabilities, which for the most part provide treatment for adults and children. In addition, there are a number of hospitals which have specialized services in different categories. Some hospitals and some retraining services are set up on a regional basis, as well as centrally. The regional type of hospital and medical facility has gradually developed since World War II.

A Regional Institute at Nancy is for physical, vocational and social rehabilitation. There is also a regional service hospital at Nancy, a rehabilitation center at Gondreville, a children's rehabilitation center at Flavigny, and schools for physical and vocational therapy. The vocational rehabilitation center consists of a resident treatment center, a gymnasium, and a vocational training unit.

Coordination of medical with the vocational training services at Nancy was initiated in 1953 when, on request of the Faculty of Medicine of Nancy, a department of Industrial and Rehabilitation Medicine was established in the central hospital. This step helped to establish rehabilitation within medicine and prepare organizationally for its acceptance.

The Hotel des Invalides in Paris, and the Cochin Hospital in Paris, LeCentre de Reeducation Motrice at Fontainebleau, and l'Hospitale Raymond-Poincare at Garches, are good examples of regional hospital-rehabilitation centralization similar to that of Nancy.

Legislation passed in May 1955, required all industries employing more than 10 persons over 18 years of age to give preference in employment to veterans and victims of war up to 10 percent of total personnel. On January 1, 1964, a law that reserves 3 percent of all jobs in private enterprise for handicapped workers went into effect. It will not change preference provisions for veterans and other war disabled, but will apply to all workers with a few exceptions in agriculture, mining, and shipping.

Civilian war disabled received little or no help from the impetus for rehabilitation that resulted from World War I. The extent of disablement following World War II among private citizen and military personnel was very great. It was the passage of the Social Security Laws of 1945, that first officially provided the civilian disabled with the right of aftercare and vocational rehabilitation. Under this legislation, employers assume the whole cost of work-injury provisions; for other benefits the cost is borne by contributions from the employee and employer. Responsibility for general supervision of rehabilitation is lodged with the Ministry of Labor and Social Security; administration is through a Directorate of Social Security in the Ministry and a national, regional, and local Social Security Fund organization. Work-injury benefits include medical care and appliances. The law makes provisions for retraining disabled persons whose employment was interrupted by resistance to the enemy and who were unable to take up their former work. Priority in the use of public or private training was provided for and employment preferences of such workers as had the requisite vocational qualifications.

Vocational rehabilitation services for the disabled were first provided through organizations and institutions, the establishment of which was stimulated by private initiative and supported from voluntary sources. As an example, in 1926, the Premiers Association de Malades was founded to help the physically handicapped to enable them to recover their economic independence. In 1929, the Ligue pour l'Adaptation due Diminue Physique Travail was founded, and in 1932, the Association des Paralysis de France. Voluntary agencies dedicated to rehabilitation of special categories of the disabled or to furthering certain aspects of rehabilitation followed. Many of these continue to function as private or quasi-public organizations, such as education and welfare of the blind and the deaf, and rehabilitation services for victims of polio or cerebral palsy or for specialized services, such as rehabilitation centers, vocational training facilities, and sheltered workshops.

A voluntary organization, the Association Nationale Interprofessionnelle pour la Formation Rationelle de la Main--d'Oeuvre (ANIFRMO), acting as agent for the Ministry of Labor and Social Security established methods of testing the disabled. ANIFRMO also has developed a nationwide plan and program of vocational training for the use of the rehabilitation and vocational training centers.

Some other important organizations in the voluntary field are the National Committee against Tuberculosis, the French Association for the Paralyzed, and the Association for Rehabilitation and Vocational Reclassification, "Auxilia" and "Vivre". In addition, there are several groups of special organizations covering particular groups, such as war victims, refugees, the tuberculous, blind, deaf, diabetic, epileptic, and others.

L'Hospital des Quinze-Vingts, founded in 1254, for 300 persons blinded in the Crusades, is now an institution where blind and their families can live. It also houses one of the most renowned clinics for eye care in Europe. L'Association Valentin Haux pour les Bien des Aveugles, founded in the 18th century, and the association, Pour Nos Aveugles, are organizations whose services are provided on a nationwide basis. Greatest recognition and fame in furthering the work for the blind came to France through the creative work of Louis Braille and the production of the Braille Alphabet.

It was in 1963 that the first rehabilitation center for the blind in France was opened at Marly-le-Roi, just outside of Paris. The facility is operated under the auspices of the Association Pour Nos Aveugles and was established with funds and grants from the Ministry of Health, the National Social Security Fund, the American Foundation for Overseas Blind (AFOB), and other bequests, and local contributions. In addition, AFOB provided the training equipment and assigned an American rehabilitation expert to train the professional staff and to introduce the course of study.

American education of the deaf had its origin in France, to which Thomas Hopkins Gallaudet turned in his quest for training prior to establishment of the first permanent school for the deaf in Hartford, Connecticut. Abbe de l'Epee instructed him in signs and sent back with him Laurent Clerc, a brilliant deaf teacher of the deaf. The school of Abbe de l'Epee still stands in the outskirts of Paris and houses a large deaf pupil population. Just two years ago the 250th anniversary of Abbe de l'Epee was celebrated at the school that drew both deaf and hearing professional and lay people from all parts of the world. Two other schools are maintained in Paris. Other schools are maintained throughout the country, some under auspices of the State and others the church.

Summation

The general system of Social Security of salaried workers in commerce and industry takes an interest in the improvement of conditions of the physically handicapped, i.e., subjects afflicted with:

1. Surgical ailments
2. Neurological complaints
3. Chronic rheumatism
4. Orthopedical and congenital deformations
5. Sensorial handicaps

The Social Security system intervenes in all fields of the therapeutical chain-prevention, care, professional readaptation, social reinstatement and the housing of persons physically handicapped.

The forms of intervention of the Social Security occur in two ways:

1. The taking in charge of the expenses for the various treatments.
2. Participation in the creation of specialized establishments either by:
    a. Direct creation, or by:
    b. Financial assistance to public or private collectivities of charities or institutions.

The Ministry of Social Affairs and Public Welfare provides for vocational rehabilitation through hospitals, rehabilitation centers, clinics, workshops, and home treatment. Pre-guidance examination, general cultural or vocational courses, and retraining for a different occupation are offered all in need.

Welfare Departments of the responsible governmental organizations, or of the Departmental Administration of the Ministry of Labor, administer the following:

1. Social Security
2. Social Aid and Welfare Work
3. Work Department of the National Office of ex-Servicemen, etc.

These programs are provided in collaboration with the Secretariat of the "Commission Departmentale d'Orientation des Infirmes" (Department for the Guidance of Infirmed Persons). Most of the programs are carried on with the cooperation of voluntary organizations.

A Technical Guidance Committee (Commission Technique d'Orientation) gives advisory service to the representatives of the Ministry of Labor, Social Security, Public Health Administration, and ex-Servicemen. Examples of this service are:

1. Direct employment (part-time work or full-time).
2. Professional training in a specialized center,contract with employer, etc.
3. Protected unfitness work.

Following World War I and continuing through the transitional period after World War II, the private and voluntary agencies carried on separate programs, making little attempt to relate the individual services to each other. Today, all of this is changed and the programs seem well coordinated.

Two legislative acts, the first in 1948 and the second in 1957, established agencies and procedures which aided in correction of the situation. An Interministerial Commission established in 1948 defined those responsibilities in the field of rehabilitation which were to be assumed by the Ministries of Labor, Health, Education, and the National Office of Social Security. This provided a framework on which to develop a coordinated effort. The 1957 Act provided for the Central Council for the Vocational and Social Reclassification of Disabled Workers, established a procedure for collecting and recording information on the incidence of disability throughout the country and promoted efforts to establish programs and build rehabilitation facilities and workshops on a national basis. All of these efforts are part of the national policy of delivering rehabilitation to its handicapped citizenry.

The Act of 26 April 1924 providing for the compulsory employment of war disabled persons may be regarded as the first legislation on the subject. It compelled employers in industry, trade and agriculture who had more than ten regular employees over the age of 18 to employ war pensioners to the extent of 10% of their total staff. The Decree of 20 May 1955 extended this obligation to all firms in the private sector, as well as national concerns, and as a secondary measure admitted among the beneficiaries certain categories of disabled workers, such as civilian victims of the war or of industrial accidents.

The next general text, however, is constituted by Act No. 57-1223 of 23 November 1957, whose provisions were harmonized with those of the Act of 26 April 1924 by Decree No. 59-954 of 3 August 1959 and Act No. 60-1434 of 27 December 1960.

This legislation provides for a number of measures for the resettlement of disabled workers.

For the purpose of this legislation a disabled worker is understood to mean "any person whose ability to find or keep employment is diminished owing to physical or mental deficiency or reduced capacity."

The classification "disabled worker" is recognized by a technical body, the Advisory Board for the Disabled, in each department. That Board gives advice on the vocational guidance of the beneficiary. The Employment Board is responsible for placing.

The general lines of this legislation:

(1) Confirm the entitlement of all disabled workers to rehabilitation, retraining or vocational training before placing and, with this in view, provide certain additional advantages (rehabilitation bonus, guaranteeing a minimum income during a training course).

(2) Provide for priority of employment both in the private and in the public sectors, and also provide special advantages additional to the labor contract, particularly as regards wages.

For firms in the private sector, the Ministerial Decree of 20 September 1963 fixed 3% as a percentage of employment. This percentage is to be added to that of war disabled men, provided that the total does not exceed 10%.

In the public sector, Decree No. 65-1112 of 16 December 1965 laid down the conditions for the employment of disabled workers by the State department and municipalities. They may obtain such employment as part of the proportion according to category of job, by means of "reserved posts", or by normal competition.

The wage for disabled men whose output is considerably diminished cannot be reduced below the 20% limit of the SMIG without preliminary authorization by the Advisory Board for the Disabled or by the Departmental Director of Labor and Employment (Decree of 7 February 1964).

(3) Regulate the various forms of protected work for all those whose disablement prevents their placement in a normal working environment.

Protected workshops have, as often as not, been established on the initiative of associations of disabled persons. The State contributes to the operational expenditure on approved workshops that it approves after consulting the Higher Council for the Vocational and Social Rehabilitation of Disabled Workers.

Disabled workers receive a wage proportionate to their output.

(4) Provide for the granting of loans on trust to disabled workers directed into independent activity, according to the rules set out in Decree No. 64-1006 of 22 September 1964.

(5) Institute a label indicating the origin of products manufactured by disabled workers (Article 3 amended by Act No. 65-975 of 19 November 1965) (5).

References

1. "ANRTP," Pont Aux Choux, Paris, 1970

2. "Comite National Francais De Liaison Pour La Readaptation Des Handicapês." 38, BD. Râspail, Paris 7^e, 1961

3. Fitzpatrick, Thomas K., *Rehabilitation Programs and Facilities of Western Europe*. U.S. Department of Health, Education and Welfare, Washington, D.C., 1963

4. "Les Cahiers De La Vie Quotidienne." Comite National Francais De Liaison Pour La Readaptation Des Handicapés, 38, Boulevard Raspâil, Paris 7^e, 1970

5. "Partial Agreement in the Social and Public Health Field," Joint Committee on the Rehabilitation and Resettlement of the Disabled, Council of Europe, France, 1969

6. "Réadaptation." 10, Kue De Sévres, Paris VII^e, N^o 177, 1971

7. "Readaptation Professionnelle des Handicapes en France." Comite National Francais De Liaison La Readaptation Des Handicapes, 38 BD. Râspail, Paris 7^e, 1967

8. *Rehabilitation of the Disabled in Fifty-One Countries*. U.S. Dept. of Health, Education and Welfare, Vocational Rehabilitation Administration, Washington, D.C., 1964

9. *Some Aspects of Medico Social Protection of the Disabled - France*. Comme National Francais De Liaison Pour La Readaptation Des Handicapes, 38 Bd. Raspâil, Paris 7^e, 1971

10. Taylor, Wallace W., Ph.D. and Taylor, Isabelle W., Ph.D. *Special Education of Physically Handicapped Children in Western Europe*. International Society for the Welfare of Cripples, New York, 1960

IRELAND

The Republic of Ireland has an area of over 27,000 square miles and a population of about 2,814,000. Its economy is largely agricultural, though there is increasing emphasis on industry. The country is small in both area and resources.

There is no complete statistical information as to the number of disabled persons in the country. Returns from health authorities show that 16,292 persons were in receipt of Disabled Persons Allowance on March 31, 1962. Such allowance is not payable to persons under 16 years of age and applicants are subject to a means test. Disabled persons maintained in institutions are not eligible to receive the allowance.

The hospital system in Ireland is excellent. She trains more physicians than are required for her population. The majority of physicians who emigrate go to Great Britain, the United States, Canada, and Australia. Of the 2,500 physicians in Ireland, about 1,500 are general practitioners, half of whom are part-time Government employees caring for the medically indigent under their National Health Program.

Under Ireland's National Health Program, free medical service is provided for all who have infectious diseases without regard to income. Patients in the middle-income group are eligible for hospital and other medical services, either free or at moderate charges. There is a voluntary health insurance scheme to assist the needs of the upper-income group in respect to the more burdensome items of medical expenses (particularly hospital treatment). The plan includes provision for vocational and other rehabilitation services.

There are many and varied organizations operating in the field of rehabilitation in Ireland.

The National Organization for Rehabilitation (NOR) was established in 1955. The organization is financed by the Minister for Health out of the Hospital's Trust Fund. Directors receive no salary for their services and they include representatives of voluntary rehabilitation organizations, local authorities, employers, certain Government departments, and other interested medical and lay people. The organization has the function of coordinating the activities of the different organized bodies engaged in the rehabilitation of the disabled and of advising the Minister for Health on future developments in the field.

Considering centers for the care of blindness, deafness, cardiac diseases in children, mental defects, orthopedic conditions, cerebral palsy, there are in Ireland about 45 institutions with approximately 4,800 beds. Between special schools, clinics, occupational therapy, and special physiotherapy units, there are upwards of 20 day centers.

In 1961, the NOR established a National Medical Rehabilitation Center at Our Lady of Lourdes Hospital, Dun Laoghaire, Co. Dublin. This institution provides extensive facilities for the medical treatment and rehabilitation of disabled persons. It has 100 beds, including a special unit for paraplegic patients. A limb-fitting unit is also there. The principal medical officer of the National Organization for Rehabilitation is the medical director of the services at the center. The center is jointly administered by a committee representative of the

NOR and the Sisters of Mercy who are in charge of the center. NOR is affiliated with the International Society for Rehabilitation of the Disabled.

St. Anthony's Outpatient Medical Rehabilitation Center, Merrion, Co. Dublin, is operated by The Irish Sisters of Charity. There, remedial treatment is given along with physiotherapy, speech therapy, remedial exercises, occupational therapy, and training in the activities of "daily living." All of these measures are employed with the aim of removing or minimizing the disabilities and developing the capabilities of the handicapped patients.

Rehabilitation Institution, Ltd., operates day training centers in Dublin, Cork, and Limerick where courses in leatherwork, woodwork, garmentmaking, secretarial work, etc., are provided. The organization also operates a residential center for men at Knockanally, Co. Kildare, where training in agriculture and horticulture is given. The institution has a well-organized placement service and operates a social center for follow-up care of disabled persons whom they have trained and placed in employment.

The Polio Fellowship trains and educates persons suffering from the after effects of poliomyelitis. It also operates boot-and-shoe-repairing workshops and a residential hostel.

The Toghemore Reablement and Training Center, Tuam, Co. Galway, provides training in woodwork, light farming, horticulture, boot-and-shoe-making and repairing for disabled men and boys, and works in close conjunction with Polio Fellowship.

NOR regards objective vocational assessment as a very important aspect of the problem of helping the handicapped to find their place in the community. Such assessment requires not only an evaluation of the patient but also a study of the requirements of the job.

A blind person who has reached the age of 21 years is eligible for a pension, subject to a means test and a residence qualification. Payments made by local authorities under blind welfare schemes are exempted in applying the means test.

Blind welfare schemes under the Blind Persons' Act, 1920, is administered by the Department of Social Welfare and is in operation in all parts of Ireland. Their general purpose is to provide for the education and training of blind persons in special schools, their industrial training and employment in workshops, their maintenance in approved institutions, and the supplementation of wages. To coordinate and centralize activities for employment in workshops, a Board for the Employment of the Blind was established by the Department of Social Welfare in 1957. The Board acquired and equipped a workshop for suitable blind workers from all over the country. The central government and local authorities assist the voluntary agencies working for the welfare of the blind to defray the cost of specialized training of blind persons who can profit by it.

There is a nonresidential center run by the Board for the Employment of the Blind at Upper Baggot Street, Dublin; 68-70 blind persons are employed here. The workshops at this center deal in basketwork and mattress making and the Board appoints teachers and employs a placement officer.

Some principal voluntary agencies working for the welfare of the blind are:

1. The National League of the Blind in Ireland which

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has among its aims the prevention of blindness and the elimination of infectious diseases of the eye, and the general protection of the interests of the blind, and the regulation of trade relations for blind workers.

2. National Council for the Blind of Ireland works for the prevention of blindness and the promotion of the welfare of the blind, by providing the home teaching and visiting service, placement service, and the provision of radio sets.
3. The Irish Association for the Blind which maintains and operates a braille printing service runs a lending library of braille publications and publishes a quarterly magazine in braille type.

There is no clear knowledge of the extent of deafness in the country. It is believed, however, that there are few, if any, deaf-mutes who are not receiving care or education and training.

There are speech therapy centers at Temple Street Children's Hospital, Dublin, National Children's Hospital, Harcourt Street, Dublin, and St. Anthony's Medical Rehabilitation Centre, Merrion, Dublin. A speech therapist also visits the National Medical Rehabilitation Center and several hospitals on a regular basis.

There is one residential clinic, operated by a voluntary body--the National Association for Cerebral Palsy Ltd.,--at Bray, County Wicklow, with facilities for physiotherapy, speech therapy, and education. This association also has a clinic and day school at Sandymount, Dublin. It is a member of the ISRD's Commission on Cerebral Palsy.

There are 15 residential institutions for mentally handicapped persons with approximately 2,703 beds.

Approximately 8,000 persons were discharged from district mental hospitals during the year 1959 and approximately 3,000 from private mental hospitals. The Rehabilitation Institution Ltd., already referred to, admits a small proportion of former mental patients to its training courses and has been successful in training and placing in employment a number of such patients.

Summation

The National Organization for Rehabilitation (NOR), established in 1955, is administered under the National Health Program. The organization's program is financed through the Minister for Health out of the Hospital's Trust Fund. Free medical and related rehabilitation services are provided handicapped individuals. Directors of the Trust Fund receive no remuneration for their services. The directors are representatives of voluntary rehabilitation organizations, local authorities, employers, government and other interested lay or professional persons. This organization coordinates the numerous activities of the different groups engaged in the vocational rehabilitation of the disabled and disadvantaged.

Rehabilitation centers and workshops for the care of the blind, deaf, cardiac, mentally retarded, mentally ill, orthopedically handicapped and cerebral palsied number over fifty, with a bed capacity of over 5,000. Along with these institutions there are over twenty-five special schools, clinics, occupational therapy units, and special physiotherapy centers.

The National Policy stresses rehabilitation to employment for the disabled and disadvantaged, when possible. The health commitment is strong and industrial cooperation is expected.

References

1. "A Placement Service for Disabled Persons." The National Rehabilitation Board, The Sheltered Workshop, Dublin, 1971

2. "CRC News," Central Remedial Clinic Sheltered Workshops, Penny Ansley Memorial Building, Dublin, 1971

3. "Hearing Aid and Educational Advisory Services." National Rehabilitation Board, Dublin

4. "Occupational Therapy." St. Joseph's College of Occupational Therapy, Dun Laoghaire, Ireland

5. "National Rehabilitation Board." Dublin

6. Rehabilitation of the Disabled in Fifty-One Countries. U.S. Department of Health, Education and Welfare, Vocational Rehabilitation Administration, Washington, D.C., 1964

7. "Youth Employment and Advisory Service," The National Rehabilitation Board, The Sheltered Workshop, Dublin, 1971

BELGIUM

The area comprises 30,506 square kilometers or C. 11,775 English square miles; and the total population is estimated to be 9,104,000. It is fundamentally a manufacturing country, but agriculture and forestry are important.

The first law in Belgium instituting a national rehabilitation program was enacted by the Belgian Parliament on 28 April 1958.

The idea of social resettlement of disabled persons was first established in the Act of 11 December 1919 on war victims. This act, which is imbued with the idea of compensation, set out to resettle in economic life citizens whose earning ability had suffered as a result of their having fought for their country.

In 1945, in the Decree of 28 December 1944, a system of social security in Belgium was established. A similar system covered other categories of disabled persons.

The social security system comprised the following sectors:

1. Sickness and disablement insurance
2. Unemployment
3. Old-age insurance
4. Family allowances
5. Annual holidays for workers

In each of these sectors, provision was made for the rehabilitation of certain beneficiaries.

In the context of sickness and disablement insurance, provision was made not only for medical benefits but also, in certain cases, for help with medical and occupational rehabilitation.

The system likewise contained provisions in respect to unemployment insurance, whereby services were available for the vocational rehabilitation of unemployed persons, whether fit or disabled.

All these legal provisions provided disabled persons with a variety of benefits, but no safeguard was given as to the continuity of a complete, coordinated resettlement program. A disabled person might well be entitled to certain benefits at certain stages in his life, depending on the legislation applicable to him at the time, without necessarily being covered by the provisions of the law throughout all the phases of the rehabilitation process.

The Belgian Government's study of the problems of rehabilitation, and especially of the coordination of rehabilitation measures for disabled persons in Belgium, took its inspiration from the research work done by the Joint Committee of Western European Union, and in particular the recommendation adopted in May 1950 (and revised in November 1958) on policy on the rehabilitation of the disabled.

The Act of 1958, known as the outline law, set the limits within which a public institution (the National Fund for the Social Resettlement of the Disabled) was able to operate and entrusted the Management Board with the task of studying the applicability of the outline law.

The Management Board, set up under this Act of 28 April 1958, established a program of social resettlement for the disabled.

The Act of 14 February 1961 dissolved the Fund set up under the Act of 28 April 1958 and conferred its powers on the National Employment Office.

A bill passed by the legislative chambers became the Act of 16 April 1963 on the Social Resettlement of the Disabled.

Under the Act of 16 April 1963, a disabled person is guaranteed all the benefits of rehabilitation, while at the same time recourse is available wherever possible to the various schemes for compensation or indemnification to which the disabled person is entitled under the relevant welfare provisions.

The Act of 16 April 1963 applies to persons of Belgian nationality - and to persons of foreign nationality meeting certain special conditions - whose prospects of employment are effectively impaired as a result of an insufficiency or diminution of at least 30% of their physical powers or at least 20% of their mental powers.

The aim of the legislature is to ensure that all disabled persons are aware of the benefits available to them under this Act, and the Royal Decree of 5 July 1963 for the implementation of this Act provides that the National Fund for the Social Resettlement of the Disabled must see to it that disabled persons likely to benefit from social resettlement are detected, by using advertising to publicize its functions and the facilities available.

Once the disabled persons are detected, the next step is to determine whether they meet the stated requirements, i.e., whether they are of Belgian nationality - or satisfy certain special conditions if they are aliens - and are suffering from a reduction of at least 30% of their physical, or at least 20% of their mental, powers.

In the text of the regulations, this operation is referred to as "registration". Registration is applied for by the disabled person himself or his legal representative.

The value of functional or medical rehabilitation is acknowledged in the text of the Act of 16 April 1963.

Functional or medical rehabilitation is an extension of medical treatment proper, in that it provides the disabled person not only with the best medical care but also with facilities for training his residual capacities for productive work.

The Royal Decree of 5 July 1963 spells out the services on which the National Fund may call in the context of this medical or functional rehabilitation. They are:

(a) the determination of the origin and nature of the condition, and the treatment to be applied;

(b) the usual medical and pharmaceutical services;

(c) surgical treatment;

(d) treatment either by the doctor or by auxiliary rehabilitation staff as prescribed by the functional rehabilitation specialist, in particular physiotherapy and occupational therapy;

(e) enrollment in an approved functional rehabilitation center or service;

(f) hospitalization in an establishment other than a center or service as mentioned in (e);

(g) the supplying, fitting, maintaining and replacing of prostheses and orthopedic appliances.

It is the duty of the National Fund to advise the disabled person of the medical or surgical treatment most likely to ensure the highest degree of functional recovery and make him able, or better able, to take employment.

The Fund also has to bear the cost of the disabled person's recommended rehabilitation treatment, either in whole or in part, where this is justified, having regard to any part of the cost borne otherwise in accordance with the law or other regulations, or by the disabled person himself or his family.

This last provision established the residual character of the legislation of 16 April 1963 by requiring the National Fund to intervene only when the other bodies involved in compensation or remedial action have fixed their share in the cost of the benefits provided.

In Belgium, two types of centers were established; first, multi-purpose, multi-specialty centers in which a precise diagnosis, which is often difficult, and medical rehabilitation, can be carried out with every possible safeguard; and secondly, single specialty or multi-purpose centers responsible for carrying out subsequent checks and prognoses but mainly concerned with the application of rehabilitation techniques.

The National Fund for Social Resettlement pays some 60% of the cost of building, furnishing and equipping functional rehabilitation centers, and also subsidizes their operation.

Belgium has a network of vocational guidance centers and psycho- medico- social centers. These services are available for the guidance of all persons, whether fit or disabled.

The work which these centers have to do makes it difficult for them to specialize in the problems of the disabled, and they are often faced with very real difficulties when they are required to advise certain disabled people whose disability is such, or so serious, that they cannot be treated in the same way as normal persons.

The legislation provides for specialization in the vocational guidance services available to disabled persons. Such guidance must take account simultaneously not only of the requirements which arise from the person's character, occupational skill or inclinations, but also of the possible repercussions on his behaviour of the guidance given and of his employment prospects.

Accordingly, under the legislation of 1963, the National Fund may have recourse to two types of institutions:

- "ordinary" institutions, i.e., educational or vocational guidance bureaux or psycho- medico-social centers;
- "specialized" institutions, i.e., vocational guidance centers or services set up under the Act of 1963.

Under the Regulations drawn up in the framework of the National Rehabilitation Programme, the special skills of certain vocational guidance officers and psychologists are recognized by the approval of such officers and psychologists as competent to:

(a) either assess intelligence, or

(b) to assess intelligence and personality.

There are approximately 100 such approved practitioners.

The National Rehabilitation Programme provides for three ways in which the National Fund for the Social Resettlement of the Disabled can assist in this matter:

1. It may help with travel and accommodation costs when disabled persons attend an ordinary education establishment and incur exceptional expenditure in travelling to it;
2. It may pay the costs of vocational training, i.e., course fees, teaching materials, etc., where the persons concerned are regarded as undergoing

vocational training, i.e., when their courses constitute a direct means of access to an occupation;

3. It may pay special allowances when courses are regarded as vocational training, leading directly to employment, or when the studies have been interrupted or their cost is so high that the person concerned, or his family, could not bear it without hardship.

Vocational training for disabled persons is generally provided by the educational establishments as an extension of general education.

The Royal Decree of 5 July 1963 lists the following types of vocational training arrangements for disabled persons:

1. School education required for placement purposes and assimilated in particular cases to vocational training, rehabilitation or retraining.

   This assimilation is decided by the Management Board of the National Fund within the limits and conditions laid down by the Ministry of Labour and Employment.

2. An apprenticeship in industry, business, the Merchant Navy or fishing.

3. A special apprenticeship for the vocational rehabilitation of disabled persons.

4. A training or vocational rehabilitation contract entered into:

- either with one of the national employment office centers providing rapid occupational training courses for adults,
- or, with another center providing a similar rapid course.

5. A training or vocational rehabilitation contract entered into with a training or vocational rehabilitation center for the disabled.

   Such a contract must be entered into with a center for the training or vocational rehabilitation of disabled persons, with priority given to disabled persons registered with the National Fund.

The Royal Decree of 5 July 1963 defines the obligations of a disabled person bound by a training or vocational rehabilitation contract (these obligations being intended to ensure the success of his training), and also defines the center's obligations toward the disabled person.

A special apprenticeship contract must be entered into through the intermediary of the National Fund and with its approval. It is concluded between the disabled person or his legal representative and the employer.

The National Fund may withdraw its approval in specified circumstances.

It is essential to note that the above-mentioned person may be employed in a sheltered workshop.

During his vocational training or rehabilitation, the disabled person is covered by the social security scheme if he is bound by a training or vocational rehabilitation contract or a special apprenticeship for the vocational rehabilitation of the disabled.

He also receives allowances and supplementary wages which, together with the indemnities and allowances payable to him as a disabled person, must bring his earnings up to the amount of the allowances paid to fit workers admitted to vocational rehabilitation schemes by the National Labour Office.

In addition, the National Fund for the Social Resettlement of the Disabled refunds the travel and hiring expenses incurred by such people in travelling to, or living in, the place where they receive their training or vocational rehabilitation.

In the Act of 16 April 1963, the Belgian Parliament established the following principles:

(a) compulsory employment of disabled persons in private, industrial, commercial and agricultural enterprises;

(b) compulsory employment in government departments and public utilities;

(c) employment or self-employment in trades and crafts;

(d) employment in sheltered workshops.

The Act places an obligation on private enterprises, government departments and public utilities to employ disabled persons.

It should be pointed out that the Ministry of Labour and Employment organized a national campaign for the resettlement of the disabled in 1970 and 1971, which was aimed particularly at firms and employment possibilities.

It is important to mention here that, in order to assist with the integration of disabled persons into economic life, the Belgian Programme provides that the State may:

1. pay a share of the wages and social charges payable by the employer;
2. pay for any job modifications;
3. contribute towards the cost of tools and clothing;
4. contribute, in exceptional cases, towards the travel costs of certain disabled persons.

Private firms employing at least 20 staff are required to employ a certain number of disabled persons who meet the conditions of Article 1 of the Act (nationality and percentage disability). This number of disabled persons is fixed by the Crown for each sector of activity on the advice of the competent joint committee, or where no such committee exists, on the advice of the National Labour Council.

The number of disabled persons to be employed by government departments and public utilities is laid down in an order issued by the Council of Ministers.

Arrangements have, therefore, to be made in this connection.

It is pointed out, however, that a Royal Decree of 1 December 1964 already makes provision for special rules on the admission of disabled persons to "public" employment.

The employment or self-employment of disabled persons in trades and crafts is also encouraged by the Royal Decree which stipulates that the National Fund shall grant or back loans, with interest or interest-free, in money or in kind, to a disabled person whose training or social resettlement prospects justify this form of assistance.

The legislation also provides for disabled persons to be employed in sheltered workshops when the nature or gravity of their disability makes it impossible for them to be employed in a normal firm.

In certain cases, the disability is so serious that the person concerned is incapable, either temporarily or permanently, of working in normal conditions.

This does not mean - far from it - that such disabled persons are completely unemployable.

Special workshops known as "sheltered workshops" have been created for them, to provide conditions in which they are able to work.

By the suitable allocation of individual tasks and adjustment of the rate of work, these workshops are organised in such a way as to take account of the occupational abilities of each disabled person employed in them.

Quite clearly, since the labor force in such workshops can hardly compete with that in ordinary firms, sheltered workshops suffer at the outset from a lack of economic viability which has to be compensated by appropriate assistance on the part of the public authorities.

The assistance granted by the National Fund for the Social Resettlement of the Disabled is of three kinds:

- operating subsidies;
- grants for the establishment, extension and fitting up of workshops;
- participation in the cost of wages and social charges, participation in staff remuneration and in the cost of industrial health services.

While sheltered workshops are undeniably uneconomic to begin with, it is nevertheless important to bear in mind that, in view of the very considerable support which they receive from the public authorities, such workshops can achieve remarkable economic and financial results, provided they organise their production wisely and are continually on the lookout for economically rewarding and competitive work.

It is obvious that, in the present-day economic situation, sheltered workshops can play an appreciable part, particularly in the field of subcontracting.

While the results achieved by the national program are distinctly positive, as is apparent from the preceding sections, it is in the sheltered workshops that the most spectacular progress has been made.

The Fund pays up to 60 percent, with a ceiling sometimes applied, of the cost of establishing, extending and fitting up these workshops.

In addition, it pays the workshops a sum of 3,900 Francs per quarter for each disabled person employed in them.

However, the most important factor is undoubtedly the share of the wages and social charges paid by the National Fund, which grants sheltered workshops a subsidy of 70%, and in some cases 100%, of the remuneration paid.

It should not be inferred from a consideration of these arrangements that the economic viability of sheltered workshops is, as it were, guaranteed by the National Fund. The problem facing these workshops are many and varied and make life extremely difficult for them, at least in the initial stages.

It will be realized that a great many precautions have to be taken when a sheltered workshop is opened in order to ensure, in the first place, continuity in the work and, in the second place, economic viability.

The success or failure of a workshop of this kind undoubtedly rests on the choice of work, the choice of workers, and last but not least, the choice of those responsible for day-to-day management.

Where the director of a sheltered workshop has both a good business sense and a sense of social responsibility, the workshop is almost certain to achieve its objective.

We would in no way suggest that these two qualities are the only guarantees of economic viability, but it is surely safe to say that they are powerful trump cards.

The effects of applying this policy of promoting sheltered workshops have not been slow in appearing; it met a real need which had often been expressed but was always held back by the lack of coherent action and reliable support.

Before 1963, sheltered workshops had systematically to look for ways of ensuring their livelihood, and in the last resort they were dependent on charity.

The rise in the numbers of sheltered workshops is significant in this respect.

Starting with 18 approved sheltered workshops in 1958, the numbers have risen as follows:

1964 : 36
1965 : 46 (+ 10)
1966 : 58 (+ 12)

1967 : 78 (+ 20)

1968 : 88 (+ 10)

1969 : 102 (+ 14)

31.12.70 : 114 (+ 12)

The number of workers employed in them rose over the same period as follows:

751 in 1964

1,190 in 1965

1,860 in 1966

2,488 in 1967

3,386 in 1968

4,219 in 1969 and

5,095 on 30.9.70

It is apparent from these two sets of figures for sheltered workshops and workers that while the number of such workshops has only trebled in the space of six years, the number of people working in them has increased more than sixfold.

This means that some existing workshops have increased their work capacity by extending either their premises or the nature of their activities, and that new workshops have planned their activities on a larger scale than would have previously been possible.

Another encouraging factor is undoubtedly the change which has taken place in the concept of the sheltered workshop itself.

Whereas, prior to 1963, workshops for handicapped people were often regarded as places where these "unfortunates" came to earn a little money, they have now taken on the structure of real firms where workers receive wages and are affiliated with a social security scheme.

This in itself would not mean a great deal, were it not that it goes hand in hand with a considerable change in the attitude to disabled workers and the atmosphere inside the workshops.

Whereas, before 1963, it was rare to find a sheltered workshop anywhere but in old dilapidated buildings abandoned by industry, it is now common to find workshops whose premises and fittings are on a par with buildings in the new industrial zones.

All these factors together help disabled persons, many of whom have had no opportunity hitherto to do a job of any kind, to work happily in bright, well-ventilated buildings and a dynamic, reassuring atmosphere.

It is very gratifying to find that a great many products on the market have been either manufactured or handled, in whole or in part, by people in sheltered workshops, without any publicity (which we would regard as unhealthy) being given to the fact.

The promotion of sheltered workshops, and the changes in their structures and the attitudes toward them, have quite clearly been encouraged both by the rules for approval and subsidy drawn up by the National Fund, and by the subsidies and other forms of assistance provided.

It often happens that the social resettlement of disabled persons is impeded by various obstacles of a material kind.

In particular, certain disabled persons need:

- to have their car adapted so that they can drive it themselves;
- to have their homes altered to enable them to move about without difficulty and make use of

modern amenities;

- to buy essential apparatus - for example, many blind people need a recorder and a great many people with motor disabilities need a wheelchair.

In such cases the National Fund for the Social Resettlement of the Disabled makes social assistance grants to help meet expenditures incurred in compensating for the material disadvantages of a disability.

It is also pointed out that the National Fund can also make special awards to disabled persons who have achieved particular distinction in the professional, sporting or cultural field.

The various aspects of this Belgian rehabilitation program have not only had a direct effect on the resettlement of the disabled, but have also helped to create a completely new psychological atmosphere surrounding the problem of the disabled, in which pity and charity have given way to a more realistic approach through effective action.

The Ministry of Labour and Employment organized in 1970 and 1971 a massive information campaign which included films, the holding of a school's competition, the distribution of folders, the sending of a message to all employers in Belgium, and the organization of lectures, seminars and press conferences, all this with the aim of bringing about a better understanding of the disabled and, hence, of the objective value of their labor.

Public opinion seems to have responded particularly well to these measures and the Belgian delegation is endeavoring to evaluate their actual impact.

Summation

The Act of 11 October 1919, amended by those of 16 April 1929, 28 June 1956 and 10 July 1957, set up the "Oeuvre Nationale des Invalides deguerre" (O. N. I. G.).

A Royal Order of 11 October 1957, amended by another of 25 February 1960, makes this public institution responsible for looking after, in every way, the material and moral welfare of the disabled. Some of its responsibilities are:

- To ensure that general or specific medical or pharmaceutical treatment for all types of infirmities, whether a result of war or not, is provided free of charge. This aid is given according to the scale fixed by the Ministerial Order of 30 December 1959, amended by that of 17 July 1963.
- To supply, repair or replace prosthetic and orthopaedic appliances necessitated by war injuries. The O. N. I. G. has a committee on prostheses which is responsible for approving suppliers of prosthetic appliances and for fixing prices.
- To promote the vocational rehabilitation and resettlement of the beneficiaries. Vocational rehabilitation is a facility granted on the basis of fairly generous rules, but in theory it is permitted only if the disabled person is unfit to pursue his former occupation or if his

wages are not adequate to provide a decent standard of living for him and his family.

- The capacities and aptitudes of the disabled person must first be established by medical/psychotechnical examination for vocational guidance purposes to ensure that apprenticeship or studies will be of benefit. These examinations are carried out by either the normal or the specialized vocational guidance services or by the medico-psychosocial resettlement center at the headquarters of O. N. I. G. Rehabilitation is effected either collectively, in an ordinary or a special school, in a center set up by the National Employment Office to provide a rapid course in vocational training with skilled craftsmen or in industry.
- During the apprenticeship period the disabled person is paid a subsistence allowance from which social security payments must be deducted, and which is subject to the supervision of the National Social Security Office.
- The cost of apprenticeship is borne chiefly by the O. N. I. G. which pays the course fees, the cost of books, standard equipment, etc. and travel expenses.
- To grant loans to promote the employment of disabled persons in a craft or independent occupation.

- To see that adequate employment is found for the disabled person in an occupation compatible with his physical condition and to ensure on his behalf, that he is given the regulation priority on public posts and recommend him, if need be, to employers in order to achieve his reintegration in the labor market.

In addition to the O. N. I. G., the Oevre Nationale des Anciens Combattants (National War Veterans Association) (Acts of 15 March 1936, 15 July 1939, 28 March 1951, coordinated by the Royal Order of 13 September 1951 and amended by the Act of 28 June 1956) is responsible for protecting all the material and moral interests of its beneficiaries. Some of its responsibilities are:

- To take or cause to be taken in their favor, all necessary or opportune measures, in particular in the matter of education, apprenticeship, vocational retraining, assistance in finding work and with Social Security; and to act similarly when the age of the disabled person, his injuries or infirmity, make social assistance necessary.
- To take action with the competent authorities to help disabled persons to obtain financial assistance, particularly for the purpose of finding employment in a craft, trade or profession, or of purchasing a house or land. The aim of vocational training is to do everything possible to provide

the best possible conditions for the exercise, with maximum efficiency of the occupation or profession best suited to the disabled person.

Coordination of policy for the employment of disabled persons is the responsibility of the National Fund for the Social Resettlement of the Disabled (FNRSH).

By virtue of Section 22 of the Act of 16 April 1963 on the Social Resettlement of the Disabled, the National Employment Office is responsible for finding employment for disabled persons who have registered with the FNRSH, who have completed rehabilitation courses, and who are fit to work in private firms.

To this end, the National Fund requires disabled persons who are fit for and seeking work to register with it.

Every precaution is taken to assure that all disabled persons for whom employment is found, are physically fit and have the skills required to do the work offered them. The policy of promoting the vocational training and rehabilitation of disabled persons, which in some cases enabled such persons to acquire higher skills, makes it possible for the FNRSH to find suitable selected employment for them.

Section 21 (1)(1) of the Act of 16 April 1963 on the Social Resettlement of the Disabled makes it compulsory for all industrial, commercial and agricultural undertakings employing a staff of more than twenty to employ a certain proportion of disabled persons. Provision is made for representatives to have a voice in fixing the percentage of disabled persons who must by law be employed in various types of undertakings.

The number of disabled persons who must be employed in each branch of activity is to be fixed by Royal Order.

Four essential measures, the cost of which is borne by the National Fund, have been adapted to further the reintegration of disabled persons into the economy. They are as follows:

- A contribution from the Fund to wages and social charges for a maximum period of one year is provided for by Ministerial Decree of 22 January 1968. This measure applies only for a limited time and is justified not by the lower output of the disabled person, but solely by his greater difficulty in adapting to the work because of his disablement.
- The Ministerial Order of 17 March 1965 specifies when and how a financial contribution may be made to the cost of providing a suitably fitted work bench.
- Provision is made in the Ministerial Order of 17 March 1965 for a contribution to the cost of tools and working clothes as part of the policy to encourage the employment of disabled persons.
- The Ministerial Decree of 17 November 1965 prescribes that the National Fund may grant or guarantee loans when the employment of a disabled person so requires.

According to Section 21 (1)(2) of the Act of 16 April 1963 on the Social Resettlement of the Disabled, public authorities and public utility companies are obliged to employ a certain number of disabled persons (a Royal Order under discussion by the Government is

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to lay down the number of disabled workers who must be employed).

Since employment in a public department carries with it substantial advantages for the employee, the Royal Order of 30 March 1939 laid down very severe rules for recruitment which were relaxed considerably in the Royal Order of 1 December 1964: no obstacle is set in the way of a disabled candidate provided employment in a public post, involves no danger either to himself or to others and he is physically and mentally fit for the work.

To mark its determination to promote the full integration of the disabled person into the staff structure, the grounds for his rejection must be communicated to the National Fund if he is registered with it. The Fund subsequently sends its observations on the decision to the Health Department.

With a view to ensuring that the largest possible number of disabled persons is gainfully employed, consideration has been given to those who are incapable of holding their own in a normal firm. Provision is made in Section 23 of the Act of 16 April 1963 on the Social Resettlement of the Disabled for placing such disabled persons in sheltered workshops.

It is the responsibility of the National Fund for the Social Resettlement of the Disabled, whose task it is to implement this policy, to increase the number of sheltered workshops. This encouragement takes the form of various types of grants which are made subject to fulfillment of the obligations which official recognition places upon such workshops.

Provision is made in legislation for subsidies to sheltered workshops to ensure their proper running or to enable them to be expanded.

A Ministerial Order of 17 March 1965, providing for grants toward the running costs of recognized sheltered workshops, has already resulted in the distribution of large sums of money to them. This has subsequently been modified and completed by Ministerial Decrees of 14 May 1965, 24 December 1965, 19 February 1968 and 8 April 1971 (5).

References

1. "...st Pourtant égaux." La Readaptation Et Le Reclassement Social Des Handicapes, Ministre De La Prevoyance Sociale, Rue Belliard 54, 1040 Bruxelles, 1970

2. Fitzpatrick, Thomas K., Rehabilitation Programs and Facilities of Western Europe. U.S. Department of Health, Education, and Welfare, Washington, D.C., 1963

3. "Le Handicapé dans la Communauté," Campagne Nationale 1970, Fonds National De Reclassement Social Des Handicappes, Rue du Meiboom 14, 1000 Bruxelles

4. "L'employeur Et Le Handicape," Le Guide De L'employeur, Le Fonds National De Reclassement Social Des Handicapes, Rue du Meiboom 14, 1000 Bruxelles, 1971

5. "Partial Agreement in the Social and Public Health Field," Joint Committee on the Rehabilitation and Resettlement of the Disabled, Counsel of Europe, Belgium, 1969

6. Taylor, Wallace W., Ph.D. and Taylor, Isabelle W., Ph.D., Special Education of Physically Handicapped Children in Western Europe. International Society for the Welfare of Cripples, New York, 1960

THE NETHERLANDS

The Netherlands or Holland has a population of approximately 11,721,416 and an area of 12,616 square miles. It has a large dairy industry and 30 percent of the area is devoted to domestic and commercial farming. Industries include shipbuilding, machinery manufacture, chemicals, textiles, brewing, and electrical and radio manufacturing which enable her to be one of the leading nations in commerce and industry.

Voluntary societies for the care and training of physically and mentally handicapped were first organized in the latter part of the 19th century.

Up to the end of World War II, medical was the only aspect of rehabilitation of the disabled for which facilities and a program had been developed.

Medical care and rehabilitation programs for the disabled are provided for under a compulsory health insurance program supervised by the Ministry of Social Affairs and Public Health. The program is operated through a network of over 100 privately managed funds. Medical care is provided by private physicians and hospitals through an arrangement similar to the U.S. Blue Cross and Blue Shield plans. An Individual requiring rehabilitation services may be referred by a physician to a hospital or rehabilitation center. Physical therapy treatments may be obtained on prescription of a physician. These centers are in different sections of the country, and in nearly all of the 11 Provinces there are Foundations for Rehabilitation (Revalidatie Stechtingen). Each center has a staff of a doctor, nurses, social worker, and administrative officer.

In addition to the centers involved in rehabilitation, there also are the Government Insurance Bank and three Federal Labor Unions. There is an Old-Age, Invalidity, and Survivors Insurance System, supervised by the same Ministry, under which covered members are entitled to sickness cash benefit allowances.

An acute labor shortage followed the war and this provided impetus to development of vocational retraining and job placement aspects of rehabilitation. The Municipal Social Employment Provision for Manual Workers was established in 1949 by the Ministry of Social Affairs and Public Health. The basic purpose of the program was to find production work suited to capabilities of unemployed manual workers, particularly the disabled, and to assist the workers to restore and increase their working capacity. The work to be undertaken is intended to be in open competitive employment. In any event, whether the work was in competitive employment, sheltered employment, or at home, the work was to be productive and add to the nation's resources. An important goal also is for each disabled worker to attain complete rehabilitation insofar as possible, of his working capabilities.

Most local communities assumed responsibliity for aiding war disabled individuals to obtain retraining and job placement. A board, made up of three representatives of the community and three members of trade unions, guides the program of each indivudual. Out of this has developed a program of sheltered employment workshops organized by the municipalities but supported by State subsidies. By 1959, there were around 22,400 people thus employed, 9,800 in open-air projects and 12,600 in sheltered workshops. The largest category, nearly 18,000, were the physically and mentally handicapped.

Provision is made by the government for selection and placement of the disabled through the district labor exchange offices. In the 1930's officials were appointed in several larger cities to assist the disabled in finding employment. There now is a placement officer at each labor exchange office who is especially trained for the placement of handicapped persons. In each Province there is one who is specifically trained to help the blind. The labor office can assist the disabled person in various ways, such as place him in a normal industrial job at full wage if practicable; give him additional training if necessary, and pay him an extra allowance during the training period; send him to a Government training center if he needs training for a new occupation; place him in a sheltered workshop if this seems the best solution, from which in some instances he moves on into industry (by 1956 nearly 200 sheltered workshops had been established, with about 7,000 employees); provide him with work in his own home setting, if there is adequate supervision and contact with a nearby sheltered workshop and give him training for a new occupation by means of a correspondence course as in the case of patients at a sanatorium.

The Government plays a major role in the fields of vocational training and placement, but in all other aspects of rehabilitation, the influence of the voluntary agencies is present. Government and private rehabilitation efforts are coordinated by an advisory council on rehabilitation. There are some 20 or more private foundations or societies concerned with the care of the disabled. Their functions which are growing and expanding are coordinated by the Netherlands Central Society for the Care of the Disabled, organized in 1899, which is the principal national organization instrumental in developing the general program for the disabled. The Society maintains a social work staff which provides consultation services to agencies throughout the country. The Society is the national affiliate organization of the International Society for Rehabilitation of the Disabled (ISRD).

Among the rehabilitation departments or centers and workshops are the following:

The Rehabilitation Department, Rotterdam, is a separate wing of a large hospital. It was established in 1959. The department receives patients chiefly from Rotterdam and surrounding areas. The program of the department is closely allied to a teaching hospital and consultant services are available. The medical staff consists principally of orthopedic specialists.

The District Sheltered Workshop in Dordrecht was established in 1952 as a community workshop by the Alderman of Social Welfare of Dordrecht. In 1954, it was made a District Social Workshop under the program of the Municipal Social Employment Provision for Manual Workers. An admission committee of the workshop receives referrals from the office of social support of the individual's home community. His referral is discussed by a medical and workshop review team to determine the program to which he will be assigned. Control reports of progress are maintained on all workers to determine improvement in each case.

The categories of work tasks performed normally under subcontract arrangements include manufacture of electric motors and vacuum cleaners, wiring assemblies for television sets and record players, assembly of electric switches, manufacture of locks and hardware, also of steel furniture for institutions, welding work, lacquer and spray painting, addressograph and stamping work. Outdoor work includes maintenance of public gardens, parks, and forests. Virtually all forms of disability are represented among the workers. Financial support comes from the State and from the municipalities, but the profit from subcontract work provides a major part of the operating budget.

The Military Rehabilitation Center at Doorn provides a program of posthospital treatment. Patients are provided social and vocational counseling to assist them in adjusting to civilian life. Almost all financial support comes from the State.

Rehabilitation Center of the Social Insurance Bank at Amsterdam was established around 1950 and serves Amsterdam and a large surrounding area. This center's program is directly related to the large Burger Hospital.

The Princess Beatrix Polio Foundation Center in Rotterdam was established in 1960 to provide comprehensive care and treatment of postpolio victims suffering from severe respiratory disability due to paralysis.

The Children's Rehabilitation Centers at Beetsterwaag and at Arnheim, are operated by privately established foundations known as the Cornelia Stitching and Johanna Stitching, founded respectively in 1915 and 1900. The center at Arnheim, established in 1959, has been developed as a completely comprehensive rehabilitation center for children with their medical, educational, and social-psychological needs all centered in one facility. The vocational and occupational therapy sections are integrated with the entire program.

The center at Beetsterwaag, established in 1915, was originally a sanitorium for children. Following the polio epidemic of 1956, its chief emphasis has been on medical rehabilitation.

Voluntary contributions, the support of foundations and State and Provincial welfare funds provide the finances necessary for the operation of most of these institutions.

St. Maartens Rehabilitation Center at Nijegen which was established in 1925 and sponsored by a Roman Catholic organization, handles nearly 300 men, women and children. It has a comprehensive program of occupational therapy and vocational training. Financial support is received from foundations and the State through the Ministry of Social Affairs and Provincial welfare agencies.

The Netherlands Organization of the Blind which was established in 1947 coordinates all important institutions for the blind. The Foundation for the Rehabilitation of the Adult Blind, founded in 1954, provides social work, counseling and psychological services and arranges for training and other services for the blind who are over 21 years of age. It develops placement and employment opportunities for this disabled group.

In addition to the above, there are four workshops which provide employment for blind persons, two libraries with braille publishing facilities and a guide-dog center service. Three organizations of the blind also offer some service to supplement those of the schools and institutions. There are four schools for the education and vocational training of the blind children and adults.

Vocational training, education, guidance and placement are available for all categories of the disabled. The blind can receive training to become typists, stenotypists, telephone operators or office workers.

To train blind boys for employment in normal industrial situations, new machines are being used. Deaf boys can receive training in typesetting, shoemaking, baking, housepainting, masonry, cabinetmaking and metal working, while deaf girls, like blind girls, are given domestic science training to become housewives or housekeepers.

SUMMATION

The Industrial Accident Act of 1921 provides for rehabilitation treatment (financed by the "Sociale Verzekerings--Bank") as well as for the treatment of occupational diseases, the payment of allowances during the period of vocational rehabilitation and the supply of appliances.

The 1966 Industrial Disability Insurance Act replaces the provisions on long-term benefits to incorporate in the 1921 Industrial Accident Act on accidents in agriculture and the 1919 Act on accidents to seafarers.

The general Special Sickness Expense Act (1967) has now guaranteed special medical care for the whole population of the Netherlands, in particular long-term nursing for the physically and mentally handicapped.

Several socio-medical aspects of this scheme have considerable importance for the development of the nursing care and opportunities for rehabilitation provided for handicapped persons.

Effective treatment and medical care, ensuring that maximum use is made of possibilities for rehabilitation, may enable a great many handicapped persons to return to playing a part in society. One essential condition for this is the existence of adequate financial arrangements for medical treatment and nursing care.

The purpose of this insurance scheme is to make possible benefits and measures connected with medical treatment and care, including arrangements designed to maintain, re-establish or improve capacity for work or to improve living conditions. The nature, content and scope of these arrangements are to be laid down by decree. It has already been established that the insurance scheme will not cover the first year spent in a hospital, sanatorium (for TB patients) or psychiatric hospital.

The 1947 Disabled Persons Employment Act entitles any disabled worker to be registered as such at the State Employment Exchange of his home district. It lays down a compulsory percentage to be employed by all firms. Guaranteed wages are also laid down for disabled persons doing a normal job.

For the purposes of the Disabled Persons Employment Act of 1 August 1947, "disabled persons" means those who as the result of mental or physical deficiencies, disabilities or disorders are materially incapable of earning a living by their work.

The Act applies to public and private firms. Any firm with a staff of more than 20 must employ at least one disabled person if its total staff is not more than 50, and at least one additional disabled person for each additional 50 staff thereafter. The Act provides for the publication of regulations to define certain categories of firms for which this proportion may be charged and to extend the obligation to certain firms with a staff of less than 20. Fines are prescribed for infringements of the Act.

The employer is required to provide tools and machinery specially designed for use by disabled workers and equipped with appropriate safety devices.

The Welfare Employment Act of 1967 laid down that in the future the public authorities will assume responsibility for creating and maintaining suitable employment for all handicapped persons having need of it.

The Central Government has responsibility for promoting adequate opportunities for employment, and hence for organizing these. The Act provides for co-management by local authorities who have been entrusted with promoting these employment openings. It is thus their task to nominate persons able to benefit by being placed in a sheltered employment; they also are responsible for creating suitable employment or fostering the creation of welfare employment by other bodies.

Local committees have been set up to put this policy into effect, while a central committee advises the Government on general questions.

Representatives from the headquarters of the generally recognized trade unions sit on both the local committees and the central committee (8).

References

1. Aangepaste Werkgelegenheid, Wet Sociale Werkvoorziening, Uitgave Van het Ministerie Van Sociale Zaken en Volksgezondheid, NV Drukkerij Ando, Den Haag, 1969

2. Black, Bertram J., *Industrial Therapy for the Mentally Ill in Western Europe*. Altro Work Shops, Inc., Bronx, N.Y., 1965

3. "Documentatie," Ministerie Van Sociale Zaken En Volksgezondheid, Directie Complementarire Sociale Voorzieningen

4. Dolnick, Michael M. "Sheltered Workshop Programs in the Netherlands and England," U.S. Dept. of Health, Education, and Welfare, Social and Rehabilitation Service, Rehabilitation Services Administration, Washington, D.C., 1970

5. Fitzpatrick, Thomas K., *Rehabilitation Programs and Facilities of Western Europe*. U.S. Department of Health, Education, and Welfare, Washington, D.C., 1963

6. *Rehabilitation of the Disabled in Fifty-One Countries*. U.S. Dept. of Health, Education, and Welfare, Vocational Rehabilitation Administration, Washington, D.C., 1964

7. *Social Employment in the Netherlands*. Ministry of Social Affairs and Public Health, 73 Zeestraat, Dan Haag, 1969

8. "Partial Agreement in the Social and Public Health Field," Joint Committee on the Rehabilitation and Resettlement of the Disabled, The Netherlands, 1969

9. "Social Security in The Netherlands," 1971

10. Taylor, Wallace W., Ph.D. and Taylor, Isabelle W., Ph.D., *Special Education of Physically Handicapped Children in Western Europe*. International Society for the Welfare of Cripples, New York, 1960

11. "Toch aan de Slag," aangepaste arbeidsmogelijk-heden voorgehandicapten

SWITZERLAND

The Swiss Confederation consists of 22 Cantons with a republican and federal constitution. It is situated in Central Europe and bounded north by Baden and Württemberg (Germany), east by Vorarlberg and Tirol (formerly Austria), with a small principality of Liechtenstein lying between Vorarlberg and Switzerland, southeast and south by Trentino, Lombardy and Piedmont (Italy), and southwest, west and northwest by the departments of Haute Savoie, Ain, Doutas, Haute-Rhin (France).

The population of Switzerland on 1st December 1960: 5.4 million inhabitants. The principle cities are Zurich and Berne. Locarno, Schwyz and Glarus are important centers. Industry and agriculture are the important areas of commerce.

Rehabilitation is understood to be all the measures aiming at the reintegration of sick or disabled persons into society. In Switzerland, the rehabilitation of the disabled has received a strong impetus since the general disability insurance scheme was introduced. Therefore, the following statements will, in the first place, give a survey on the benefits provided by the Swiss disability insurance scheme and, secondly, expound the measures and the organization of the insurance within the field of the rehabilitation of the disabled into economic life.

I. The Benefits Provided by the State Disability Insurance Scheme

1. The Federal Disability Insurance Act, which came into force on 1st January 1960, gives the basis for comprehensive and effective assistance to all the disabled. There were indeed measures in favor of the disabled already before the intro-

duction of this Act. These efforts were certainly manifold, but very often they were not coordinated. The state accident insurance provided for pensions, medical care and prostheses, but not for vocational measures for the employees who had been the victims of accidents. The state military insruance scheme safeguarded persons in military service against the consequences of all impairments to their health suffered in connection with military service, and paid sickness benefits and pensions. The sickness insurance knew some benefits in case of disability (e.g. daily allowance in case of long illness). So did the numerous public and private superannuation-funds. Furthermore, the private institutions of public utility did extremely valuable work in order to improve the hard condition of the disabled. They are in particular Pro Infirmis, the Swiss Association against Tuberculosis (Schweiz. Vereinigung gegen die Tuberkulose), the Association of Swiss Self-Help Organizations of the Sick and the Disabled (Arbeitsgemeinschaft schweiz. Krankenund Invalidenselbsthilfeorganisationen), the Swiss Association for the Rehabilitation of the Disabled into Political Economy (Schweiz. Arbeitsgemeinschaft zur Eingliederung Behinderter in die Volkswirtschaft), and others.

However, these measures lacked a common basis, and a universal coordination of the single measures was only made possible by the Federal Disability Insurance Act. Since 1960, Switzerland has had a modern regulation as concerns the rehabilitation of the disabled.

2. The principal characteristics of the disability insurance scheme are as follows:

   a. The disability insurance scheme protects the insured persons from the economical consequences of disability. It provides benefits only when the disability causes a diminution of the earning capacity (or of the capacity of work in the case of housewives).

   b. In principle, the cause of the disability is unessential; disability can arise from sickness, accident or congenital infirmities. It is of no importance whether the disability is physical or mental.

   c. The rehabilitation measures have the priority on the pension benefits; the latter are paid only when a rehabilitation attempt gave no result at all or only an insufficient one, or when it appeared hopeless from the very beginning.

   d. The insured persons have a legal right to the grant of the legal benefits; they may appeal against any decision to the appeal authorities.

e. Disability insurance is universal and compulsory. It includes not only the employed persons but also the self-employed in industry, business, arts and crafts, agriculture and in the liberal professions; furthermore the persons not gainfully occupied (children and housewives). All the persons who were already disabled when the scheme came into force are also submitted to the insurance and receive benefits.

3. The benefits available in the individual cases under the disability insurance scheme are of different kinds. There are two main classes of benefits, the rehabilitation measures on the one hand, and the disability pensions on the other hand, the former being granted for a limited time, the latter lasting a long period. Rehabilitation measures can be granted from birth forward, and pensions from twenty years of age (in special cases already eighteen years of age) forward, till they cease to be granted when the recipients qualify for old-age pensions (i.e., at the age of 65 for men and 63 for women).

Pensions are payable if the degree of disability is at least 50 percent (or 40 percent in cases of hardship). In addition to this, the disabled who is in needy circumstances and particularly impotent is entitled to a helpless person's allowances.

4. Apart from the direct grant of benefits, the disability insurance scheme pays subsidies to institutions for assistance to the disabled, i.e., subsidies for the construction, establishment and renovation of institutions and workshops (special schools, institutions for uneducable minors, hospitals, rehabilitation centers, sheltered workshops, homes for the disabled, etc.) and subsidies for the running of these institutions and workshops.

   The scheme also subsidises the organizations for private assistance to the disabled, in connection with the work of advising and attending the disabled and their relatives, providing special courses designed to increase their skill, training experts and teachers for the care, instruction and vocational rehabilitation of the disabled.

II. The Rehabilitation of the Disabled into Economic Life

The most important aspect of the disability insurance scheme is that concerned with the rehabilitation of the disabled to enable them to resume gainful activity. When a disabled person applies for assistance under the scheme, the first step taken is that of ascertaining whether his earning power can be restored or improved by rehabilitation. The following are the rehabilitation benefits available under the scheme:

1. Medical Measures

a. In General

With the reservation of paragraph b, insured persons are entitled to such medical measures as are directly required for purposes of vocational rehabilitation, but do not aim at the treatment of the infliction as such, and are likely to improve the earning power of the disabled lastingly and importantly or to prevent a substantial reduction of it. Thus the treatment of an infliction or an accident as such is not assumed by the disability insurance, the provision of medical treatment in these cases lying within the province of the sickness and accident insurance schemes.

The medical rehabilitation measures consist mainly of surgical, orthopedic and physiotherapeutic treatment given in a limited period.

b. In Cases of Congenital Infirmities

As congenital infirmities are generally not covered by the sickness insurance scheme, the disability insurance scheme pays the entire cost of the medical treatment of such infirmities until the person concerned reaches his majority.

2. Vocational Measures

a. Vocational Guidance

Vocational guidance is of particular importance for the disabled. An insured person whose disability is such as to be an obstacle to his choice of an occupation or to continuance of his previous occupation is entitled to vocational guidance from officials specially trained to provide it. If the disabled cannot attend the vocational guidance offices during working-hours or receive an official at his home, arrangements can be made to ascertain his abilities in an institution by means of aptitude tests and practical work tests, which take rather long.

b. Initial Training

The disabled who has not had any previous occupation and whose initial training involves substantial additional cost, because of his disability, is entitled to benefits insofar as the training is appropriate to his aptitudes. In such cases, the disability insurance scheme will assume the additional cost involved by disability. Reputed as

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initial training as any training which the disabled receives after having frequented the elementary or the special school and before beginning a gainful activity. In principle, any kind of training is taken into account, i.e., not only apprenticeships and shorter training, but also studies at high and technical schools and at universities, vocational preparation to auxiliary work or to sheltered employment, and training in housekeeping.

c. Retraining

Where a person is, or is likely in the near future to be, suffering from a disability which will make it much more difficult, or impossible, for him to continue in his previous occupation, the disability insurance scheme pays the entire cost of retraining him for an activity corresponding to the nature of the infirmity and the faculties remaining him, or that of any measure necessary to enable him to continue with his previous activity in spite of his disability.

d. Placement Facilities

As far as possible, suitable work will be found for the disabled who can be rehabilitated. Thus, the insured person has no right to obtain a job, but only to require the efforts of the competent specialized services of the disability insurance scheme.

The disability insurance scheme knows neither a right of the insured person to work nor an obligation of the employers to employ the disabled. However, there are no practical difficulties in placing the disabled, as the Swiss employers are willing to cooperate.

e. Capital Aid

A capital aid can be granted to a disabled insured person in order to set or reset him in business on his own account.

3. Special Schooling and Subsidies for Uneducable Minors

a. Special Schooling

Special schooling consists of instruction for disabled young persons whose disabilities prevent them from attending ordinary schools or restrict their ability to do so. In such cases, the disability insurance scheme provides for contributions towards school fees, and - for the children in boarding-schools - also towards board expenses; further towards the travelling expenses. Special schooling is absolutely necessary for many disabled young persons - in particular for the blind, deaf-mute and mentally defective children - if their vocational rehabilitation is eventually to be successful.

b. Pedagogic Measures for Children of Preschool Age

Disabled children of preschool age are already entitled to contributions towards school fees and board expenses, if they must be prepared for special schooling by particular pedagogic measures (this concerns mainly the deaf, the hard of hearing, the children with speech impairments and those with sight defects).

c. Additional Medico-Pedagogical Lessons

Minors who are hard of hearing and those who have serious speech impairments receive contributions towards the cost of an additional course in lipreading and of logopedic treatment, enabling them to attend lessons at the elementary school.

d. Measures Enabling Disabled Children to Frequent School

In order to enable disabled children (e.g., children with poliomyelitis sequelae) to frequent elementary school, the disability insurance scheme assumes the transportation cost to school, which is involved by disability, up to an amount of 50 Swiss francs per month.

e. Subsidies for Uneducable Minors

In certain circumstances, the scheme pays subsidies for the maintenance, in an institution or at home, of uneducable minors.

4. Auxiliary Equipment and Appliances

The loss or impairment of bodily functions can partly be offset by appliances. The disability insurance scheme provides disabled persons capable of being rehabilitated not only with orthopedic appliances such as prostheses, sustaining apparatus, etc., but also with all other appliances necessary for travelling to and from work and for the performance of an occupational activity. To enable disabled persons to travel to and from work the scheme may provide motor vehicles (e.g. for the persons with poliomyelitis sequelae), or guide dogs for blind persons, or a part of the cost of engaging another person to accompany them. Deaf persons are provided with hearing aids. In addition, the scheme pays the cost of special arrangements and installations required to adapt workplaces for use by the disabled (e.g. special tools, typewriters and dictaphones for the blind, modifications to machinery, special seats and work tables).

5. Daily Allowances

While a disabled is undergoing rehabilitation according to chapters II/1/a and II/2/a and c, he is entitled to a daily allowance as well. This allowance is designed to ensure the subsistence of the disabled and his dependents while he is undergoing rehabilitation. The daily allowances payable under the scheme are deliberately fixed at higher levels than the pensions payable, in order to provide an incentive to undergo rehabilitation.

III. The Organization of Rehabilitation

The Federal Office for Social Insurance, acting as supervisory authority of the disability insurance scheme, sees to the scheme's being applied according to uniform principles by the executive organs mentioned below (sections 1/a and b). All the organs mentioned in section 1 (but not those in sections 2 and 3) are under its supervision. The scheme has its own organs (section 1) to examine the individual cases and make the decisions as regards the appropriate rehabilitation measures, and also the pensions and the allowances for helpless persons. In return, the practical execution of the rehabilitation measures is incumbent on institutions alien to the scheme; it is controlled, however, by the scheme's own organs.

1. The Scheme's Own Organs

a. In each case, the 104 compensation offices, which are distributed all over the country, report their formal decision to the disabled. From such a decision, each insured person can see his rights. He may appeal against it to the appeal authorities (see section 3).

b. The 27 disability insurance committees, which are distributed all over the country, examine each case in particular for the compensation offices which report the decisions. They decide which measures will be granted to the disabled (retraining, delivery of appliances, etc.). Each disability insurance committee consists of a physician, a lawyer, a social worker, a rehabilitation expert and an employment market expert.

c. For the disability insurance committees, the 11 regional offices, which are distributed all over the country, examine the cases regarding above all the vocational rehabilitation measures. They have at their disposal a staff specialized in vocational guidance and placement.

d. The Central Compensation Office deals with the coverage of the cost of the rehabilitation measures applied by the institutions and services mentioned in section 2. Besides, it performs other central tasks such as the keeping of a central register on the insured persons and the settlement of accounts between compensation offices.

2. Institutions Alien to the Scheme

The practical rehabilitation work (application of rehabilitation measures such as initial training, special schooling of a deaf-mute child, surgical treatment and hospitalization of an insured person, etc.) is not performed by the scheme's own organs or institutions. The state disability insurance possesses neither physicians and hospitals of its own, nor retraining centers and sheltered workshops, nor depositories for appliances, etc. However, the scheme has enough institutions at its disposal, with which it cooperates on the basis of agreements.

Furthermore, the services of the private assistance to the disabled in particular (e.g. associations of disabled persons and self-help organizations of the disabled) help the state insurance scheme. They are at its disposal to perform mandates, and organize courses and manifestations subsidized by the scheme and accessible to all the disabled (e.g. courses in lipreading for the deaf-mute, courses for the physical training of the disabled, courses for advising parents of disabled children, etc.).

Finally, it should be mentioned that the Swiss employers spontaneously use every effort to procure jobs for all the disabled who are capable of keeping their place in economic life without foreign help or through rehabilitation measures.

3. Legal Protection of the Disabled

If a disabled does not agree upon the decision taken by the compensation office as regards the rehabilitation measure required of him, he may appeal, free of charge, to the appeal authorities of first instance, and further to the Federal Insurance Tribunal, the highest court as regards social security, against the decision taken by the authorities of first instance.

Summation

The Federal Disability Insurance Act came into being on 1st January 1960. It establishes the basis for comprehensive and effective assistance to all the disabled of Switzerland. The State accident insurance provides for pension, medical care and prostheses.

The most important aspect of the disability insurance scheme is that concerned with the rehabilitation of the disabled to enable them to resume gainful activity. When a disabled person applies for assistance under the scheme, the first step taken is that of ascertaining whether his earning power can be restored or improved by rehabilitation. The following are the rehabilitation benefits available under the scheme:

1. Medical Measures
2. Vocational Measures
    a. Vocational Guidance
    b. Initial Training
    c. Retraining

    d. Placement Facilities
    e. Capital Aid
3. Special Schooling and Subsidies for Uneducable minors
4. Auxiliary Equipment and Appliances
5. Daily Allawances

The Federal Office for Social Insurance, acting as supervising authority of the disability insurance scheme, sees to the scheme's being applied according to uniform principles. The scheme has its own organs which examine the individual cases and make the decisions as regards the appropriate rehabilitation measures, and also the pensions and the allowances for helpless persons. In return, the practical execution of the rehabilitation measures is incumbent on institutions alien to the scheme; it is controlled, however, by the scheme's own organs.

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The Swiss employers spontaneously use every effort to procure jobs for all the disabled who are capable of keeping their place in economic life without foreign help or through rehabilitation measures.

References

1. Granacher, Albert. "Rehabilitation in Switzerland," Federal Office for Social Insurance, Berne, 1963

2. "Pro Infirmis." Association Suisse, 8032 Zürich

3. *Rehabilitation of the Disabled in Fifty-One Countries.* U.S. Dept. of Health, Education and Welfare, Vocational Rehabilitation Administration, Washington, D.C., 1964

4. "Social Welfare in Switzerland." Swiss National Conference on Social Welfare, Brandschenkestrasse 36, 8039 Zürich, 1969

5. "Stadtführer für Behinderte." Zürich

6. Taylor, Wallace W., Ph.D. and Taylor, Isabelle W., Ph.D., *Special Education of Physically Handicapped Children in Western Europe.* International Society for the Welfare of Cripples, New York, 1960

AUSTRIA

Austria has a population well over 7,073,000 and an area of over 32,370 square miles. World War II and two successive enemy invasions and occupations imposed severe hardships on a country already beset by economic crisis and revolution. Postwar economic stability, however, has enabled it to develop important social welfare programs, including the introduction of modern techniques for the rehabilitation of the handicapped. A rough estimate has placed the number of severely or totally handicapped persons in Austria at 210,000, children who have some measure of physical handicap at 350,000 and the mentally handicapped at 210,000. The number of blind persons is estimated at 4,000.

Austria has, traditionally, always supported rehabilitation services. Institutes for the deaf and dumb were established in Vienna during the 18th century, for the blind in 1804, for the speech handicapped in 1897, and for crippled children in 1907. Also, Austria has a highly developed hospital system and its ratio of physicians to population (1 in 610) is among the highest in the world.

The Federal General Social Insurance Act[1] provides general social insurance including sickness, accident, and pension insurance schemes. Nearly every person in Austria is included in the program and thus entitled to remedial treatment, aftercare and care in the case of illness leading to a permanent physical handicap. Social insurance pays for prostheses and special apparatus, while the social welfare organizations pay the cost of special care for the patient. The purpose of accident insurance is preventive and, among other provisions, includes occupational rehabilitation.

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[1] Figures for 1957 indicate that for the entire country there were over 5,000 children attending either kindergartens or special schools in the following categories: Blind, partially sighted, deaf and dumb, hard of hearing, crippled (including cerebral palsied), and speech handicapped.

Austria's federal laws give certain categories of handicapped workers (including blind persons), equal employment rights with war veterans, and employers are required by law to hire a certain proportion of handicapped persons. Monetary incentives are also offered, through the Federal unemployment insurance fund, to induce employers to hire the handicapped workers over and above the required quota.

There is a special designated department for the Rehabilitation of the Physically Handicapped under the Ministry of Social Welfare. This department supervises the activities of the Special School for Technology originally established in Vienna for the training and retraining of handicapped war veterans and later extended to handicapped youth. It provides three-year specialized classes, also six and twelve-month preparatory and trial classes. Entrants are selected by the provincial labor office of the Employment Service.

Rehabilitation centers throughout the country are maintained and administered by the Social Insurance Institutes, with vocational guidance supplied by the provincial labor offices which take responsibility for placing rehabilitated persons in jobs. The labor offices also arrange for additional training and retraining of older and handicapped workers, both within and outside plants and as individuals or in groups.

Several hospitals offer physical therapy services and there is an amputee center at Kufstein.

There are a variety of services for children and youth including two major rehabilitation centers for handicapped children and five special schools where crippled children receive vocational training after they have completed elementary school.

Youth-at-work programs for the handicapped are carried out in three cities, where numbers of the physically handicapped are separated into groups for special training.

Services for the blind include three residential schools for children and adults. There are three workshops which offer major employment opportunities for blind adults. Vocational training in the schools and workshops is primarily in the crafts for shorthand, secretaries, typists, telephone operators and music.

The major provisions of their Federal law are these: Any disabled person shall have an alternative claim to one or more of (1) medical and vocational rehabilitation, (2) protected jobs and (3) monetary benefits. The choice shall be made by a rehabilitation team in consultation with the disabled person.

Vocational rehabilitation shall not be granted to persons above old-age pension eligibility age (men 60, women 55), nor to persons who already have a claim against social accident (workmen's compensation) insurance or the veterans and Nazi victims administration. The administration makes use of existing public or private institutes by way of making contracts under civil law.

Protected jobs, either individually in ordinary plants or in special sheltered workshops, are created by way of subsidies which do not exceed the alternative monetary benefit. The age limit for sub-

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sidized sheltered jobs is 65 for men and 60 for women.

It is estimated that around 70 percent of rehabilitation work in Austria is being performed by the Federal Government but a vital role is played by the voluntary agencies.

The Workshop for the Care of the Physically and Mentally Handicapped was founded in 1950 and initiated the first seminars for the training of occupational therapists and other service groups; and, in general, has publicized the need for rehabilitation services. Caridas, which is a religious organization, has provided social aid and rehabilitation for the physically handicapped. The Oesterreichische Arbeitsgemeinschaft fuer Rehabilitation in Vienna is an affiliate of the International Society for Rehabilitation of the Disabled (ISRD). It specializes in social care for physically handicapped persons. The Austrian Mental Hygiene Association, the League against Polio, and the Austrian Society for the Rights of the Child are also active in the field.

National Vocational Training Center, Vienna, is for handicapped adolescents. It offers three years of vocational training in mechanics, individual management, leatherwork, upholstery; also retraining and additional training.

National Institute for Deaf-Mutes, Vienna, offers a kindergarten, school and vocational training for girls age 3 to 18.

Institute for the Blind, Vienna, is for children and adolescents. It offers kindergarten, school and vocational training.

Occupational Therapy Courses for Severely Disabled, Vienna, offers occupational therapy training to severely disabled persons, 40 percent of whom are under 18 years of age.

School for Handicapped Children, Rodaun, provides eight classes for children between the ages of 6 to 20.

Waldschule, Wiener Neustadt, in lower Austria, provides schooling and vocational training for handicapped children.

Provincial Training Center for Handicapped, Gratz-Andritz, offers complete vocational training for boys and youth between ages 8 to 25.

Rehabilitation Center, Tobelbad, provides medical and professional rehabilitation of severely handicapped paraplegics. Occupational therapy and vocational guidance are provided, but no vocational training.

Rehabilitation Center for Handicapped Children, Hermager, provides medical and social rehabilitation for handicapped children.

Child Guidance Clinic, Salsburg, with inpatient and outpatient departments, provides examination and observation of mentally handicapped, maladjusted and physically handicapped children.

Special Kindergarten and Home at Klangenfurt, is a child guidance clinic that serves children not able to attend either a regular or special school but who can still be educated.

Workshop for Handicapped of VOEST, Luiz, provides social and vocational rehabilitation and reemployment of the handicapped.

Summation

Rehabilitation of military and civilian war victims is regulated by the War Victims Assistance Act of 1957. It is the expressed aim of rehabilitation, according to that Act, to reintegrate the injured persons into the economy or to improve their position therein. This Act provides for occupational training and retraining, curative treatment and supply of prostheses.

If the previous occupational training of the injured person was interrupted due to war injuries, or if he can no longer carry out his previous profession because of a war injury, occupational training or retraining has to be continued until he is fully reintegrated. During occupational retraining, the injured person is entitled to allowances sufficient to maintain his standard of living and that of his family. He is also covered by social insurance during the period of occupational retraining.

Every injured person is entitled to curative treatment if he needs it because of a war injury. War victims who are totally incapable of working are also entitled to curative treatment for other illnesses. The curative treatment is aimed at improving the health and earning capacity of the injured person in order to prevent deterioration and to ease his hardship. To this end, medical treatment, hospital care and sickness benefits help to compensate for the loss of income during treatment.

Finally, the injured person is entitled to the supply of prostheses in order to help him overcome his difficulties caused by a war injury, and to improve his earning capacity. In a similar way to curative treatment, war victims totally incapable of working may also claim for prostheses if they need them because of other bodily injuries apart from those caused by the war. The supply of prostheses includes all technical devices which could improve the situation of a handicapped person. Blind war victims are given guide-dogs if they are able to make use of them.

Rehabilitation measures for victims of accidents during peacetime military service are provided for, after the war, in an Act of 1964 ("Heeresversorgungsgesetz"). The provisions of this Act, in general, follow the regulations for military and civilian war victims. But, of course, the rehabilitation measures from which these persons benefit are substantially greater than for war victims. This results from the fact that the number of victims of this kind of accident are fortunately far lower, and thus receive a greater degree of individual attention in the light of recent technical progress. In addition, persons concerned in this context are, as a rule, rather young.

Since 1968, there has been a Federal Act in Austria for the control of tuberculosis (Tuberculosis Act) which is progressively opening up the field of modern rehabilitation measures.

There are also special provisions for blind persons in connection with the Placing of Invalids Act.

All employers are obliged by law to reserve a certain percentage of jobs for handicapped persons whose earning capacity is reduced by at least 50%. Five percent of jobs are reserved for them. Employers with a reduced earning capacity of at least 25% can also be included in this scheme as long as the employment of the more severely handicapped workers is not endangered. Wages and salaries of handicapped employees must not be reduced on account of their invalidity. Furthermore, there are special legal provisions in this scheme for the protection of handicapped employees.

Employers who do not fulfill their obligation to employ at least 5% of handicapped workers have to pay a so-called compensatory tax. The proceeds of this tax are put into the "compensatory tax fund," to finance the welfare activities for handicapped persons, to provide special machinery enabling such persons to take part in an active working life and for the construction of convalescent and rest homes.

The implementation of this Act, namely, the "Placing of Invalids Act," is one of the duties of the authorities dealing with the labor market.

Blind persons are considered to be invalids under the Placing of the Invalids Act, whatever the cause of their blindness may be. The compensatory tax fund, administered by the Federal Ministry for Social Administration, regularly pays for the adaptation of equipment, such at that in telephone exchanges and typing and steno machines, in Braille to the needs of blind employees.

On 1 January 1969 a Federal Act on Labour Market Promotion ("Arbeitsmarktforderungsgesetz") came into force, comprising a great variety of measures in order to safeguard optimal conditions in the labor market. Amongst the measures under this Act are aids for persons whose handicap affects their competitive position on the labor market. Within the framework of these aids, special assistance for disabled persons is provided. For instance:

I. Disabled persons are given preferential treatment in finding employment.

II. Job redesigning aids are employed at the public's expense.

III. All other aids for the promotion and securing of employment are equally available for handicapped persons, and even to a special degree; for instance, testing of work aptitude and attitude, tests on the job, vocational training, retraining and further training, financial aid in the case of essential travelling or second living accommodation and related expenses, support for the purchase of work clothes and tools (3).

References

1. "Behindertenzentrum," der stadt Wien, Berufseinglieckrunge--Und Beschäftigungstherapiekurse, Seeböckgasse 12-14, 1160 Wien

2. "Legislation on the Rehabilitation and Employment of the Disabled," in the Seven States[1] Parties to the Partial Agreement and in Austria, 13th Session, 1971

3. "Partial Agreement in the Social and Public Health Field," Joint Committee on the Rehabilitation and Resettlement of the Disabled, Council of Europe, Austria

4. Rehabilitation of the Disabled in Fifty-One Countries. U.S. Dept. of Health, Education and Welfare, Vocational Rehabilitation Administration, Washington, D.C., 1964

5. Rodler, Othmar and Urbanetz, Social Security in Austria. National Federation of Austrian Social Insurance Institutions, Vienna, 1969

6. Taylor, Wallace W., Ph.D. and Taylor, Isabelle, W., Ph.D. Special Education of Physically Handicapped Children in Western Europe. International Society for the Welfare of Cripples, New York, 1960

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[1] Belgium, France, the Federal Republic of Germany, Italy, Luxembourg, the Netherlands and the United Kingdom of Great Britain and Northern Ireland.

YUGOSLAVIA

Yugoslavia, a mountainous country with an area of about 98,700 square miles, has a population of about 18,538,150. There are six Republics in its federation: Serbia, Croatia, Slovenia, Bosnia-Herzegovina, Montenegro and Macedonia. Nearly 60 percent of the land is devoted to agriculture--wheat, sugar beets, maize and hops. In recent years there has been industrial development in milling, brewing and sugar refining. The country has rich mineral deposits in bauxite, iron, aluminum, copper, and other ores. Its hydroelectric power potential ranks next to Norway's among the European countries.

During World War II, the civilian population suffered war damage and much of the large incidence of heavy disability can be traced to this factor. There are no good statistics in the total number of disabled or physically handicapped, though it is estimated there are some 20,000 blind adults and over 40,000 deaf.

In most European countries programs for the disabled were established first by voluntary effort and support but this is not the case in Yugoslavia. There was some social assistance for the blind and deaf in the mid-1800's. In 1950, with the passage of the Social Insurance Act, the first provisions for services to the disabled were established on a nationwide basis. In 1956, improved procedures were adopted under a revision of the Social Insurance Law. Services of medical rehabilitation were provided at that time, and are still provided by the national health institutions while vocational rehabilitation is under the Institute of Social Insurance and the Department of Labor.

Following 1948, the number of disabled in Yugoslavia increased beyond that resulting from World War II when disability among military and civilian population was widespread. The more recent increases are due, in part, to the movement of workers from rural to urban communities, to increased industrialisation and industrial accidents. Early methods of evaluation, based on a percentage of physical disability rather than residual work capacity, proved inadequate and measures for the provision of disability allowances and unemployment assistance were also insufficient to meet the needs of the disabled population.

Under the country's disability insurance law passed in January 1959, all handicapped persons who are unable to work are assured disability pensions and those who can be rehabilitated are given the opportunity for training and treatment so that they can return to normal employment. The law makes it clear that vocational rehabilitation and employment are principal goals in a program for the betterment of disabled persons. The administrative organisation responsible for carrying out the program is the Institute of Social Insurance.

The disabled worker in Yugoslavia is given financial assistance while undergoing rehabilitation and during the period of adjustment to work. Allowances are continued during illnesses recognized by the health insurance program. Supplementary grants are made to handicapped persons who can only work on a part-time basis. The vocational objective selected for training and employment of the handicapped person, if at a lower level than previous employment or determined capacity, must meet with the approval of the disabled person himself.

The Institute of Social Insurance has established commissions throughout the country consisting of two or more physicians, a vocational counselor, social worker, and social insurance representative. The commission reports on the medical diagnosis, assessment of residual capacity, conditions of work for the handicapped, the vocational rehabilitation services needed, and the type of employment to which the individual is best suited. The commission's assessment may be followed by that of a review board which is responsible for settling points of controversy. Employment of the handicapped may be in commercial or industrial centers, in sheltered workshops, rehabilitation centers, special institutions, etc. Commercial and industrial organizations are required by law to hire the handicapped when called upon by an agency of the Institute of Social Insurance.

Many organizations and institutions throughout the six Republics of Yugoslavia provide vocational rehabilitation services to the handicapped. Leadership in the development and provision of services, however, was provided by the Federal Institute for Rehabilitation in Belgrade. In 1952, this pilot demonstration rehabilitation center was established at Belgrade with technical assistance from the United Nations and equipment from UNICEF. The center was manned by six experts who, under the United Nations fellowship program, had studied rehabilitation methods and techniques the previous year in the United Kingdom and the United States. It has been the objective of the Federal Institute for Rehabilitation to establish national standards of treatment and training, to establish a new specialty of physical medicine and rehabilitation as graduate training in several universities, to provide continuous training for medical and technical personnel, and to establish total rehabilitation programs in each Republic where medical, educational, vocational and social aspects of rehabilitation are thoroughly integrated.

By 1957, the Belgrade center had stimulated the establishment of other centers in Zagreb, Ljubliana, Banja-Luka, and in other locations over the country. A rehabilitation department was established in the Secretariat of Public Health. A Federal rehabilitation committee was also established as advisory to the national program and to cooperate with international organizations.

The Federal Institute for Rehabilitation continues to be a research and demonstration center for trying out new programs and techniques for adoption by hospitals, centers, and vocational training programs throughout the country. The institute provides inpatient and outpatient services. The institute operates cooperatively with the University of Belgrade, with general hospitals of the city, and with the other Government agencies. The Federal institute is the national organization in Yugoslavia affiliated with the International Society for Rehabilitation of the Disabled (ISRD).

The Institution for Rehabilitation of Disabled Persons of the Republic of Slovenia, in Ljubliana, was established in 1954. This State supported institution serves the whole Republic of Slovenia. It has a comprehensive vocational rehabilitation program and works closely with the Orthopedic Clinic of the Medical Faculty of the University of Ljubliana. The institution has a resident capacity of 125 patients, male and female, ranging in age from 8 to 80. Its major focus is in paraplegics, amputees, and hip dislocation cases. The support of this center comes from the Central Government and the Republic of Slovenia.

The Valotra Hospital and Rehabilitation Center, near Koper, is approximately 80 miles southwest of Ljubliana and provides rehabilitation services to disabled persons in the southern area of Slovenia. Many types of disabled persons are served, such as the orthopedic, the tuberculous, the postpolio, and traumatic and congenital hip dislocation cases. Support of the center comes from the local region, from the Republic of Slovenia, and through Social Insurance payments by patients.

The Savoda Rehabilitation Center, Lasko, Slovenia, admits patients from all over Yugoslavia suffering from orthopedic, paraplegic, polio and neuromuscular, and other disabilities. It works closely with the medical facilities of Celje, an industrial city in the vicinity. Support of the center comes from the city of Celje, the Republic of Slovenia and Social Insurance payments of patients.

The Rehabilitation Center is located at Zagreb, Croatia, is a complex organization consisting of the Center itself, the Orthopedic and Rehabilitation Clinic of the University of Zagreb Hospital, the Rehabilitation Department of the Zagreb General Hospital, and "OSVIT" Sheltered Workshop. The center opened in 1962. Its program is closely related to the other organizations. The Orthopedic and Rehabilitation Clinic receives patients from all parts of Croatia.

The Rehabilitation Department of the Zagreb General Hospital established a rehabilitation center as part of the general hospital. Physical and occupational therapy are provided and plans have been made for prevocational and vocational training programs. This rehabilitation center program is supported as part of the overall operation of the hospital.

The OSVIT or Sunrise Workshop was established in 1957 by former tubercular patients. It provides employment to persons engaged in homebound employment. All types of disability are admitted, most recently the mentally ill. The workshop produces ceramics, ornamental iron products, plastics, and artificial flowers. The workshop is supported by its annual production which amounts to over 61 million dinars (about $100,000). Workers are paid on a piecework basis with an annual bonus.

Throughout most of the countries of Central Europe, former resort centers are located in areas where nature provided hot springs, salt springs, or a particularly warm and tranquil atmosphere. Since these factors are conducive to convalescence and recovery, rehabilitation people have been quick to make use of them. Such is the location of the Rehabilitation Center at Krapinski-Toplice, about 25 miles north of Zagreb.

The Banja-Luka Rehabilitation Center is located in the Republic of Bosnia-Herzegovina. The site is that of a former Trappist monastery. Banja-Luka has become an industrial center for the region, and the rehabilitation center is the principal facility for rehabilitation in the Republic. The center also serves the Republic of Macedonia and receives patients from other parts of Yugoslavia. The program of the center is closely related to that of the General Hospital. Vocational testing and evaluation and vocational training are well coordinated with the medical rehabilitation program. The vocational training program includes training in radio mechanics, light machine operation, electric trades, woodworking, typing, and business operations. Support for the center is derived almost entirely from the Social Insurance Fund.

The Republic of Montenegro established the Melosovitch Rehabilitation Center at Igalo and three similar centers in the Republic.

There are many institutions in Yugoslavia that provide some rehabilitation services to special disability groups and a variety of centers for crippled children. In Slovenia there is the Tuberculosis Institute and Hospital at Golnik and the centers for Rehabilitation of the Tuberculous, one at Nova-Celje and another at Topolsica, the erstwhile thermal spa referred to above. Among others, centers for crippled children are located at Kamnik and at Nova-Gorisia, and also at Zagreb.

A school for the blind in Zemun was selected to be the National Demonstration and Training Center for the Blind in order to study problems related to rehabilitation of the blind, to train staff, to establish international relationships and to gather information on the incidence of blindness.

Vocational training schools with workshops for blind adults over the age of 18 prepare the blind for such occupations as typing, telephonist, handcrafts, broommaking, brushmaking, and piano tuning. These schools are supported principally by the Government. By locating the schools in four different sections of the country, their services are brought within reach of many blind people. Schools for the education of blind children under the age of 18 are also well located to serve the blind population. The school for blind children in Macedonia is for multiple handicapped children, particularly the deaf-blind.

Summation

Yugoslavia was faced with a major problem of social, economic and educational adjustment, as well as government reorganization. A nation which had been, principally, agricultural, had to gear itself to industrial and modern means of production. Nowhere have the efforts been more rewarding than in the medical and rehabilitation fields. The United States, through its technical assistance program, has greatly aided these efforts. Advances in technology over the past thirty years are evident in the North Section of Belgrade, Zagreb, and other industrial centers.

Voluntary organizations are assisting with the rehabilitation of the disabled through governmental officials. They all work through rehabilitation centers and hospitals in Ljubliana, Zagreb, Sarajevo, Belgrade and Skopje. A number of thermal spas and coastal resort centers have been converted into rehabilitation facilities.

Vocational training and sheltered workshops are being developed but are concentrated in the urban centers. Many university professors and educators are assisting in this movement. The Ministries of Education and Social Security combine their resources to help educate and train the disabled and disadvantaged for work in industry or elsewhere. Good progress is being made in the national effort.

References

1. Fitzpatrick, Thomas K., Rehabilitation Programs and Facilities of Western Europe. U.S. Department of Health, Education and Welfare, Washington, D.C., 1963

2. Prijedlog Statuta Konferencije Za Rehabilitaciju I Zaštitu Invalidnih Osoba, Sr Hrvatske, Zagreb, 1971

3. Rehabilitacija I Zaštita Invalidnih Osoba U, Sr Hrvatskoj, Zagreb, 1971

4. Rehabilitation of the Disabled in Fifty-One Countries. U.S. Dept. of Health, Education and Welfare, Vocational Rehabilitation Administration, Washington, D.C., 1964

5. Staro, Anthony, and Gardner, Henry, "Report on Orthotics-Prosthetics Research Developments in Yugoslavia," U.S. Dept. of Health, Education and Welfare, Office of Vocational Rehabilitation, Washington, D.C., 1961

6. Taylor, Wallace W., Ph.D. and Taylor, Isabelle W., Ph.D., Special Education of Physically Handicapped Children in Western Europe. International Society for the Welfare of Cripples, New York, 1960

NORWAY

Norway covers about 10 percent of the western part of the Scandinavian peninsula. It is the fifth largest country in Europe, while second to Iceland. Its population density is the lowest. In the east, the country borders on Sweden, Finland and the Soviet Union, and has the sea as its boundary. It has an exceptionally long coastline. Along the coast there are numerous islands (about 150,000, of which only 2,000 are inhabited). Nearly three quarters of the area is unsuitable for habitation or cultivation.

The capital of Norway lies on about 60° N. This latitude runs north of Scotland, through central Canada and southern Alaska. Norway's most northern town, Hammerfest, is also the most northerly in the world, lying on 70° 39'48" N latitude. The Arctic Circle crosses near the middle of Norway, the northern most part being well-known to tourists as "The Land of the Midnight Sun".

The population of Norway is 3,867,000 (1969, estimated), which is equal to 12.5 inhabitants per sq. km (30 per sq. mile)--the dependencies not included. Or, to put it in another way--if the area were divided equally, there would be almost 100,000 sq. metres (eq. 25 acres) for each Norwegian. Approximately 48 percent of the population live in rural districts, 40 percent in towns and the remaining 12 percent in other built-up areas.

Oslo is the capital of Norway and has a population of 487,600 and a total area of 175 sq. miles. It was founded about 1048. Seat of the King, Government and Parliament and the Supreme Court are in Oslo. It is the country's leading industrial city and most important commercial and shipping town.

Trondheim (pop. 126,000), Norway's second largest city, was founded ab. 997. It is an important center for trade, industry and shipping. The cathedral Nidarosdomen, the national shrine of Norway, is located here.

Bergen (pop. 116,000) is an old shipping and trading city and the cultural center of Western Norway. It sponsors an international summer festival in May and June.

Stavanger (pop. 82,000) is Norway's foremost canning town and has also taken the lead in shipbuilding. Stavanger Cathedral from 1125.

Kristiansand (pop. 56,000) is the «capital» of the south coast and center of industry, trade and shipping.

Economic policy has been the major issue in post-war politics in Norway, with marked dissent on the questions of taxation and the degree of state interference in private trade and industry. Controls and restrictions found necessary by labor led several times to bitter political strife. A certain degree of socialization was introduced, and several state-owned industrial activities were established. On the other hand, there has been substantial agreement on foreign and defense policies, and on measures to avoid detrimental labor conflicts. Major social benefits have been achieved through cooperation between the parties, e.g. the National Insurance Scheme in 1967.

Norway's administration system is one of both central and local government. Under the civil administration system the country is divided into 20 counties, which in turn are divided into 47 urban municipalities and 402 rural municipalities. They seem to work in an orderly manner.

The work earlier done to provide vocational rehabilitation and employment for handicapped persons was largely initiated by private humanitarian organizations prior to World War II. Following World War II, the public authorities steadily became more and more involved, and it is now generally accepted that vocational rehabilitation is primarily a public responsibility.

Administrative and practical responsibility for vocational rehabilitation is shouldered by the public employment authorities, but there is also extensive and systematic cooperation with other public organs, particularly as regards pension, insurance, health and training problems. An intimate cooperation is also maintained with many private organizations.

During the period 1970-73 the Government will take up proposals for the establishment of a health and service center for the handicapped. It will be planned to receive clients from all over the country, and its main functions will be to offer:

- An information exchange and service centre for the various types of aids available to the handicapped.
- Exchange of information concerning welfare measures
- Hospital hotels
- Transit homes for handicapped
- Instruction and training for various categories of vocational personnel
- Physio-therapy, work therapy
- Courses, seminars, etc.

This center will also engage in experimental activities and research. Experience gained will, hopefully, contribute towards training of a larger number of physically handicapped persons, to the point where, given the appropriate technical aids, they can go on living and functioning in their own homes, and possibly in their places of work, rather than being forced into hospitals or similar institutions.

The following broad survey of the vocational rehabilitation work undertaken in Norway gives the picture as it is seen from the point of view of the official labor employment agencies:

Labor Exchanges

The Labour Exchange Service has a staff of 91 persons, specially trained to deal with vocational rehabilitation of the handicapped. They are employed in the county labor exchanges and in the larger local labor exchanges. In addition, there are other staff members specially trained in giving vocational guidance. In several cases there will also be a large demand for work for vocational psychologists.

Generally speaking, the rehabilitation personnel are expected to have a broad social, technical or pedagogical education and experience of practical work. They acquire further qualifications through in-service training in the Labour Exchange Service's own school and through traineeships at the State established Rehabilitation Center.

Where practical rehabilitation activities are concerned, the staff of the Labour Exchange Service cooperates with the center's physician treating the handicapped, possibly with his hospital's socio-medical ward, with the personnel at the office of the county physician (or other socio-medical experts in the county), with the Insurance Fund, with social workers and with the local social affairs offices. The program is extensive.

If a client experiences difficulty in getting his vocational problems solved in a satisfactory manner through the ordinary channels of training, including the various training courses for adults offered by the Labour Exchange Service itself, contact must be established with one of the special centers. Some of these are attached to the Ministry of Labour or are connected with the Labour Directorate. In the year 1969, 6.183 handicapped persons seeking employment were registered at the Labour Exchange as possible rehabilitation cases, of which 4.872 were men and 1.311 were women. The age groupings were as follows:

Age	Under 20 years	20-29 years	30-39 years	40-49 years	50-59 years	60 years and over	Total
Number	.768	1.600	1.026	1.387	1.104	.298	6.183
Percentage	12	26	17	22	18	5	100

The largest group of vocational handicaps stemmed from mental diseases (31%). Then followed the group suffering from deficiencies in the organs of movement (23%) and organic nervous illnesses and illnesses affecting organs of the senses (11%).

The same year 3.242 persons were provided with work, of which 2.593 were men and 649 were women.

Rehabilitation Centers

Three State operated rehabilitation centers are located in Oslo, Bergen and Trondheim. These centers first of all assist rehabilitation personnel in working out a rehabilitation plan or program for each individual client and for motivating him towards the realization of the rehabilitation process. These centers have at their disposal specialists on social medicine, work psychology, vocational guidance and social work, and form working groups to assist each individual client in solving his problems.

These centers are also in a position to dispatch working groups to regional areas in order to assist the rehabilitation personnel in making rehabilitation diagnosis and planning for local groups of clients. The centers have special wards for physical training. They also teach vocational training and readjustment in modern workshops. The centers have the possibility to undertake post-research and testing with a view to finding new rehabilitation methods for the different types of handicap. These three centers treat a total of approximately 1.000 clients per year.

1970 saw the establishment at Tromsø of Northern Norway's own rehabilitation center, and further plans for a new rehabilitation center in Oslo are expected to be ready by 1973.

Firms for Vocationally Handicapped

Following a stay in one of the State rehabilitation centers and training and assistance from the Labour Exchange Service, many handicapped persons will still not have achieved such a degree of readjustment to normal work tempo and routine that it will be practically possible - or responsible - to pass them on to normal places of work. Several special firms have therefore been established for the vocationally handicapped with the basic aim of functioning as transit firms for those who need a period in which to readjust to normal working tempo and routine before taking their place in ordinary employment. These firms provide more permanent sheltered employment.

At one time, these firms essentially employed persons with physical or mental handicaps. Currently the aim is also to readjust a strikingly wide range of persons suffering from diverse social handicaps: Alcoholics, law breakers, some of the retarded, social misfits, elderly persons having to change trades late in life, and so on--the socially disadvantaged.

Most of these firms for the vocationally handicapped are organized as ordinary joint stock companies where local authorities, organizations of the vocationally handicapped, and humanitarian organizations (as well as interested individuals and ordinary firms) have subscribed the stock capital.

At the beginning of 1970, 47 firms offering employment to a total of 1.583 persons were approved as firms for the vocationally handicapped. The initiative to set up such firms has often been taken by the officials of the Labour Exchange Service. A separate organ, known as the Order Centre for Firms Employing Vocationally Handicapped Persons (OBY), has been established under the auspices of the State Rehabilitation Centre in Oslo, which has also provided expert help in connection with the establishment of these firms. The State grants considerable financial funds for the establishment and operation of such undertakings. The employees of these firms are employed through the rehabilitation officials of the Labour Exchange Service. In each firm a rehabilitation committee is set up which, at fixed intervals, checks on the vocational progress of the individual employee, considers his pay and the chances of moving him on to an ordinary place of employment.

Individuals who have been employed by firms for vocationally handicapped approved by the Labour Directorate through the Labour Exchange Service, can obtain readjustment financial benefits from the Unemployment Insurance in the form of:

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1. Extra pay
2. Family allowance
3. Travel allowance
4. Housing allowance
5. Child care allowance

In 1968 the Storting approved the following measures:

- The number of sheltered places of work to be substantially increased.
- Special steps to secure more permanent sheltered places of work.
- More experimental activities in this field.
- The public authorities, on behalf of the firms, to endeavor to solve problems of commission and sale on a rational basis.

Transit Homes

In order to find the proper occupation many handicapped persons have to move away from home. This, of course, also happens during the rehabilitation period. Thus, there is a demand for transit homes, particularly for people whose own homes are in places going through a period of growth where there is a shortage of vocational schools, training centers for adults, and firms for the vocationally handicapped. The Labour Directorate has granted funds for the construction of new transit homes and for the completion of existing transit homes. A hostel for the handicapped is being financed from the same funds. During the current year a total of kr 750.000 have been allocated to measures of this kind.

The Central Council for the Handicapped

The development of vocational rehabilitation has depended upon cooperation between several ministries, institutions and organizations. Under the auspices of the Ministry of Labour a Central Council for the Handicapped has therefore been set up. It has 16 members, including representatives from the Labour Directorate, the Directorate of Health Services, the National Insurance Fund, the Ministry of Education, the Rehabilitation centers and the Coordinating Committee of the organizations for the handicapped. The Secretariat of the Central Council is located in the Ministry of Labour.

The Central Council advises ministries, public institutions and organizations working with rehabilitation and promotes coordination of their work. It may on its own initiative take up and consider rehabilitation questions. The Central Council has appointed several working committees. One of these has worked out guidelines for the establishment and operation of firms for the vocationally handicapped, another has published a rehabilitation manual.

Contributions from the Unemployment Insurance Fund towards readjustment of handicapped persons employed in ordinary firms

Contributions from the Unemployment Insurance Fund are granted to employers who employ difficult cases, who because of physical, mental or social handicaps need a period of readjustment before they can work at full capacity.

The situation must be of a nature that the applicant, because of his handicap, genuinely needs such a period of readjustment before he can be expected to perform his work normally.

A precondition of such grants is that efforts have, as far as practically possible, been made to implement other rehabilitation measures, including training and vocational instruction. Also, the possibilities of employment in a firm for vocationally handicapped and of transfer to the open labor market, possibly even outside the subject's original home area, must also have been very carefully examined.

The contribution consists of kr 6,-pr. executed working hour, and may be paid out for 12 weeks. If the employee after 12 weeks' period of readjustment (with contribution to the employer) has not reached an almost normal capacity for work, a further contribution for 12 weeks at kr 4,- may be granted.

It is also a condition that the employer pays standard wages to the employee from the first day of work and keeps him employed after the termination of the contributions if he performs his work satisfactorily, and gives no valid grounds for dismissal.

Types of Pensions and Cash Benefits

a) Unemployment Insurance

Pursuant to the Act of May 28, 1959, §14, pertaining to unemployment insurance, aid can be granted from the local unemployment funds towards living expenses for persons who, because of age, illness or disablement, or other special reasons, are without suitable employment, and who have small chances of getting permanent and suitable work without such aid.

Aid can be given up to a total of kr 3.000,-. With the approval of the Director of Labour, a total sum of kr 5.000 can be granted.

b) National Health Insurance Act

Pursuant to the National Insurance Act of June 17, 1966, rehabilitation aid can be granted to all persons who, because of illness or injury, have a permanently reduced capability of self-support or considerably limited possibilities with regard to choice of occupation or place of work, if such aid will help procurement of appropriate employment.

Rehabilitation aid can be granted to the extent that such aid is considered necessary and appropriate, in the form of:

1. Examination, training and treatment in a socio-medical ward in a hospital or approved rehabilitation center.
2. Contributions towards covering expenses relating to instructions, training and readjustment to schools, courses, firms, etc.
3. Contributions towards covering necessary expenses related to rehabilitation, as mentioned under 1 and 2 above.
4. Contribution to loans or to travel and/or removal expenses; towards starting up some sort of economic activity; or to other ends of decisive importance as regards the capability of the insured person to find a job.

The same aid can be given to an unmarried mother, and may also be awarded to a surviving spouse or unmarried woman who for at least 5 years has been compelled to stay at home taking care of her parents or some other close relatives.

c) Social Care Act

Persons who are not able to support themselves or to take care of themselves are eligible, pursuant to the Social Care Act of June 5, 1964, to receive social aid in a variety of forms. For example:

1. Loans, guarantees for loans, contributions to the cost of vocational training or otherwise acquiring an occupation, or for other goals aimed at rendering the applicant self-supporting.

2. Refunds in connection with work performed in "working homes" or sheltered firms, with or without residence being involved.

Summation

The work done to provide employment for handicapped persons was largely initiated by private humanitarian organizations. But after World War II, the public authorities steadily became more and more involved and it is now generally accepted that vocational rehabilitation is primarily a public task.

The administrative and practical responsibility is today shouldered by the public employment authorities, but there is also extensive and systematic cooperation with other public organs, particularly as regards pension, insurance, health and training problems. An intimate cooperation is also maintained with private organizations.

The development of vocational rehabilitation depends on cooperation between several ministries, institutions and organizations. Under the auspices of the Ministry of Labour a Central Council for the Handicapped has therefore been set up. It has sixteen members, including representatives from the Labour Directorate, the Directorate of Health Services, the National Insurance Fund, the Ministry of Education, the Rehabilitation centers and the Coordinating Committee of the organizations for the handicapped. The Secretariat of the Central Council is located in the Ministry of Labour.

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References

1. "Beretning for Tidsrummet," Optraeningsinstituttet Ved Rigshospitalet, København, 1969

2. "Cirkulaere Vedrørende Lov Om Revalidering," Social-ministeriets Cirkuloere af 22. maj 1967

3. Duva, Viggo, "Treating the Troubled Family," Danish Journal Special Edition, 1970

4. Fitzpatrick, Thomas K., *Rehabilitation Programs and Facilities of Western Europe*. U.S. Department of Health, Education, and Welfare, Washington, D.C., 1963

5. *"Social Insurance in Norway,"* The National Insurance Institution, Oslo, 1970

6. Taylor, Wallace W., Ph.D. and Taylor, Isabelle W., Ph.D., *Special Education of Physically Handicapped Children in Western Europe*. International Society for the Welfare of Cripples, New York, 1960

7. "Vocational Rehabilitation in Norway," Norwegian Joint Committee on International Policy, Oslo, 1970

DENMARK

The country of Denmark covers an area of approximately 16,619 square miles. She has a population around 4,585,256, excluding Greenland and the Faroe Islands in the Atlantic Ocean. The density of the population averages more than 100 persons per kilometer. Denmark has been a constitutional monarchy since 1849, and the Government is parliamentary. Legislative power is held cooperatively by the King and Parliament, while executive authority is exercised by the Secretaries of States and their departments. Local self-government is highly developed, particularly in regard to education, public roads, hospitals, social insurance and social services.

Approximately two-thirds of the population in Denmark is living in areas of concentrated population in and around cities and towns. Nearly fifty percent of the population is economically active and more than one-third of these is engaged in industry trade, building and construction, while agriculture, including foresty, horticulture, and fishing, employs about one-fourth. Nearly one-third of the national products is for export to other countries.

No data, to date, are available on the number of disabled persons in Denmark.

As in many economically and industrially developed countries, the care of the disabled in Denmark was first developed through private initiative, and later on, subsidized by public funds. Legislation followed. Publicly run programs were established and a measure of public control was exercised over organizations and institutions that had been started with private means and under voluntary leadership. These institutions are still largely privately run but depend, greatly, on public funds.

Another factor that has greatly influenced the development of rehabilitation for the disabled in Denmark, historically and at present, is the National Health Service which is under the Ministry of Interior. The programs for the disabled, the aged, etc., are under the Ministry of Social Affairs. This separation in administrative responsibility is reported by some to have caused delay in tackling the medical problems of disability in terms of the rehabilitation objective and to have set up a complication in achieving the coordination necessary in disabled individuals' program.

Denmark, however, has been a leader in providing care for its disadvantaged citizens and in furthering the rehabilitation of its disabled people. This they are proud of.

The Constitutional Law of 1849, legalized the responsibility of the State for seeing that no citizen should suffer material need on account of loss of, or never attained, ability to work. This is known as the "free constitution." The so-called Poor Law of 1891, laid down more exact rules concerning to whom and to what extent economic help should be given. In addition to this legislative concern for the individual, the 19th century saw the establishment by private initiative and by the Government of institutions for the care, training, and employment of large and easily identified categories of handicapped persons. For example, in 1807 an institute for the deaf and dumb was established by the Government; in 1811 a voluntary charitable organization was set up for the blind; in 1816 the first treatment for the mentally ill in contrast to custodial institutions was put in operation; and in 1855 the first institution for mental defectives was established. The care of epileptics was started in the mid-1890's, and in 1898, an institute for speech defectives was set up by the Government.

The largest, best known, and oldest institution for the disabled is the Society and Home for Cripples. The society was founded in 1872. The services provided by the society are to reduce disablement insofar as possible with medical treatment, and then by means of vocational education, and assist the individual to be self-supporting to the greatest practicable extent.

Extensive development of the programs of this society continues. It owns and runs all the orthopedic hospitals and hospital departments in Denmark. Some of these are the orthopedic hospital at Copenhagen and Aarhus and orthopedic departments at Aalborg, Kolding, Holstebro, Sonderborg, and Odense. Orthopedic workshops of the society where prostheses, other orthopedic appliances and technical aids are produced and institutions providing evaluation and a variety of rehabilitation services for the cerebral palsied are located at Copenhagen, Sollerod, Odense, and Aarhus.

The society operates two medical hospitals at Hornbaek and Hald. The society also maintains boarding schools at Copenhagen and Virum for children between the ages of 7 and 16 years who are unable to attend regular schools because of severe physical handicaps. The society's school program also includes private tuition in a pupil's home and tuition for children admitted to hospital departments. The society runs a vocational school for training disabled youths. There are 16 different types of training shops at the vocational school at

Copenhagen and boarding maintenance at the home is provided as needed. The shops are run as productive, as well as training facilities.

The Society and Home for Cripples also cooperates with local authorities in running rehabilitation centers in various parts of the country, the general purpose being to rehabilitate injured and otherwise disabled adults. These centers receive public support from the State but are run by the society. There is a Rehabilitation Clinic at Copenhagen, Sheltered Establishments and Homework Center, also at Copenhagen, and two similar institutions which provide training and work for severely disabled persons.

At most departments specially trained social welfare advisers are employed to give clients help in solving their social, economic, and vocational problems.

The Society and Home for Cripples pioneered in the establishment of services for the disabled and legislation and the assumption of public responsibility for the support of services followed. Of primary importance to rehabilitation are the National Assistance Act (1933) 1961, and the Rehabilitation Act, 1961, administered by the Ministry of Social Affairs. Of significance also are the following: The Old Age Benefit Act, 1891; the Health Insurance Funds Act, 1892; the Industrial Injury Insurance Act, 1898; the Relief Funds and Unemployment Insurance Funds, 1907, the Disability Insurance Act, 1921, and the Old Age Pension Act, 1922.

The National Assistance Act of 1961, requires the State to take care of the "education, support, maintenance, treatment, and care of disabled persons whose handicap requires that they should be treated at a State institution or an institution recognized by the State or * * * in a * * * supervised foster home * * * which is under constant supervision from an institution." The passage of this legislation made it possible for handicapped persons to receive treatment by specialists, young disabled persons to receive training in a trade or other occupation and for the handicapped in general to receive other forms of help paid in full by the State.

Special care services are provided exclusively by the voluntary institutions and organizations that receive State grants. The Special Care Services, an administrative area of the Ministry of Social Affairs with its director on the staff and under the supervision of the Ministry, is primarily responsible for the coordination of services provided by the voluntary institutions and for the prevention of duplication in service. Administrative interpretation is achieved principally by having the director of Special Care Services act as chairman of the governing boards of special category organizations. Thus he serves in this capacity on the Blind Persons Board, Deaf Persons Board, and Board for the Hard of Hearing. Services provided by institutions and other organizations to special care groups are in addition to those provided under the National Assistance Act.

The Rehabilitation Act of 1961 develops and supplements the services for disabled people. It makes available services for the handicapped not covered by special category legislation; for example, to those suffering any physical or mental disability and to those whose primary disability is due to social causes.

Any Danish citizen in need of special care or medical, vocational, or social rehabilitation is eligible for such assistance subject to no formal conditions. The kind of assistance received depends

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upon the needs of the particular disabled person and may consist of one or a combination of any of the following services: medical treatment, provision of artificial appliances including hearing aids, education, industrial rehabilitation, vocational training and retraining, and help to carry on a trade or business.

The Rehabilitation Act provides for regional rehabilitation offices (12 at present), with responsibility for counseling the disabled, for coordinating their programs of rehabilitation services and for granting financial assistance to the disabled.

The personnel of these offices are responsible for seeing that vocational assessment training or retraining and other needed services are provided the handicapped person. They do not provide the services themselves but arrange for them to be provided, by the facilities of public and privately run organizations and institutions.

Vocational rehabilitation services are designed to place the handicapped person, whenever possible, in open market competitive employment. In cooperation with public employment service, which carries general responsibility for vocational guidance, the personnel of the rehabilitation offices see that needed services are provided. For example, medical and psychological examinations necessary in securing vocational assessment are the ultimate responsibility of regional rehabilitation offices. Cooperation with special grant-aided institutions for disabled persons in furthering the rehabilitation program of the disabled person is also the responsibility of these offices.

Job placement of disabled persons is dependent upon the cooperation of workers' and employers' organizations, the National Confederation of Danish Trade Unions and the Danish Employers' Confederation.

These organizations are represented on the central cooperations committee, Rehabilitation Section of the Disability Insurance Court and on various other committees. The Disability Insurance Court decides on claims for disability pension and for the provision of various types of assistance such as the purchase of motor vehicles and financial assistance to set up an independent business. It also acts as a court of appeal from decisions of the local authorities relating to rehabilitation services.

The provisions of several special category acts are briefly described in the following paragraphs.

The Blind Persons Act, May 1950, provides for a special board, Blind Persons' Board, empowered to evaluate developments and make recommendations to improve services to the blind.

A special employment service and other special facilities designed to give the blind and partially sighted advice and guidance in setting up an independent business or trade are arranged for by the Minister of Social Affairs. Financial assistance may also be provided for the establishment of a business or other means of gainful employment. Counseling service for the blind is provided, in cooperation with the National Service, by the Danish Society for the Blind.

The Act of January 27, 1950 makes provision for services to the deaf and hard of hearing. The Act provides for the establishment of the Deaf Persons' Board, the chairman of which is the director for Special Care Services, Ministry of Social Affairs.

Three hearing centers have been set up at Copenhagen, Aarhus, and Odense. Audiological clinics have been set up at the University

Hospital, Copenhagen, and in some Provincial towns. The chief purpose of the clinics is to assist the hearing centers in granting hearing aids, vocational guidance, social guidance, and placement service.

Both the National Assistance Act, 1961, and an Act of June 1959, "Care of Mental Defectives and Other Persons of Subnormal Intelligence" make provision for services which are carried out by the National Mental Deficiency Service under direction of the Minister of Social Affairs.

Summation

The services for the handicapped fall, in all essentials, into the following three categories: "special care" services; rehabilitation services; and welfare facilities. In addition, however, voluntary organizations carry out extensive activities, with or without public support.

As regards several categories of handicapped persons, services in the fields of education, rehabilitation and care are, wholly or in part, the responsibility of the so-called "special care" services, i.e., the special care of the mentally ill, the mentally retarded and other persons of subnormal intelligence, the epileptic, the crippled, the speech defectives, the severely word blind, the blind and the partially sighted, the deaf and the hard of hearing.

The National Assistance Act requires the State to take care of persons suffering from any such disability and being in need of residential care or foster family care under supervision. It is expressly provided that the State shall be responsible for the existence of the institutions required.

The Rehabilitation Act develops and supplements the services for handicapped persons. It applies to handicapped persons other than those covered by "special care" legislation and to persons whose disability is not so severe as to require special care proper. In addition to persons suffering from any physical or mental disability, the Rehabilitation Act applies to persons whose disability is mainly due to social causes.

Any Danish citizen who is in need of special care or of medical, vocational or social rehabilitation is eligible for such assistance, subject to no formal conditions. This type of assistance depends on the circumstances of each particular case. It may, e.g. consist in maintenance, care, medical treatment, provision of hearing aid or any other aids, nursery school and school education, retraining or assistance towards vocational training. The services for the handicapped are entirely voluntary to the person concerned, except for the mentally ill and the mentally retarded, for whom care may be established or maintained against their will in very special cases on certain conditions specified by law.

Since the end of the second World War, a number of rehabilitation units (workshops) have been established through funds provided from various sources (local authorities and voluntary organizations, the Ministry of Labour, the Ministry of Social Affairs, etc.). In addition to general work adjustment, these institutions provide an actual training in industrial work under conditions being adjusted, as far as possible, to those in industry. At present, there exist some 35 rehabilitation units capable of admitting a total of 1,000 persons. The production of the workshops covers a variety of fields, such as metal, wood, footwear, textiles, paper, gardening, etc.

Vocational placing of disabled persons is not linked to any public registration of the handicapped, and employers are under no obligation to give employment to the disabled as a special proportion of their staff (quota system).

Private employers are, in addition, not required to reserve vacancies within particular occupational fields for handicapped persons. Under the Rehabilitation Act, on the other hand, a Royal Order was issued on 30th September 1965, giving preference to disabled persons for certain occupations in Central and Local Government undertakings, and in institutions which carry out their activities with public recognition and support. The idea is that, where it is not possible to get a disabled person settled in open employment, the public employment exchanges shall notify the public authorities, etc. within the area. Whenever manpower is needed in the occupational field of the handicapped, the competent authorities, etc. shall consult the employment exchange about engagement of the handicapped. When the handicapped is considered as qualified as any other candidates, the authorities are obliged to engage him.

References

1. Asmussen, Ph.D., Erlins, Fredsted, Ll.B, and Ryge, M.D., Else, "Communications from The Testing and Observation Institute of The Danish National Association for Infantile Paralysis, Hellerup, Denmark, 1959

2. Bjórnsen, Mette K. and Bramsen, Ludvig E. (editors), *Facts About Denmark*. Politikens Forlag A/S, Copenhagen, 1969

3. Engberg, Eugenie, *Rehabilitation and Care of the Handicapped* Ministries of Labour and Social Affairs, Copenhagen, 1967

4. Fitzpatrick, Thomas K., *Rehabilitation Programs and Facilities of Western Europe*. U.S. Department of Health, Education, and Welfare, Washington, D.C., 1963

5. *Rehabilitation of the Disabled in Fifty-One Countries*. U.S. Department of Health, Education, and Welfare, Vocational Rehabilitation Administration, Washington, D.C., 1964

6. Taylor, Wallace W., Ph.D. and Taylor, Isabelle W., Ph.D., *Special Education of Physically Handicapped Children in Western Europe*. International Society for the Welfare of Cripples, New York, 1960

7. *"The Rehabilitation Act, No. 170,"* dated 29 April 1960, as Amended by the Act. No. 231, dated 8 June 1966, Ministries of Labour and Social Affairs, Copenhagen

8. "The Retraining Institute at the University Hospital Copenhagen," The University of Copenhagen, Copenhagen, 1970

9. "The Society and Home for Cripples in Denmark," Copenhagen, 1966

SWEDEN

Sweden has a population of approximately 7,495,129 and an area of 173,649 square miles. About 9 percent of its land is tillable and nearly 53 percent is forest. The major occupations are lumbering, mining and manufacturing. The urban movement of population over the past years has left only around 30 percent of the people living in rural districts.

Rehabilitation of the disabled in Sweden is a responsibility of both central and local governments, with private organizations for the care of the handicapped playing an important but subsidiary role.

The central governmental agencies responsible for the program are the Kgl. Medicinalstyrelsen (National Medical Board) and the Kgl. Arbetsmarknadsstyrelsen (National Labor Market Board), in cooperation with the Riksforsakringsverket (National Social Insurance Agency) and the Kgl. Overstyrelsen for Yrkesutbildning (National Board for Vocational Training). On the local level, the counties and four cities which combine a county's functions with those of a municipality discharge the responsibilities assigned to them under the national program in close cooperation with the Provincial subsidiaries of the national agencies.

The Government maintains cooperation with both central and local level of organizations for the handicapped. These organizations receive substantial subsidies from the Government. They provide specialized services, recreational facilities, special technical aids, and financial support for specific groups of handicapped persons (e.g. the blind, polio victims, rheumatics). Through their national joint organizations, Svenska Vanforevardens Centralkommittee (SVCK), the organization for the care of persons with orthopedic handicaps conduct research, develop and produce new aids to meet general and individual need, and send information to the organizations for the handicapped.

Vocational rehabilitation, i.e., the stage of rehabilitation which begins after or runs parallel with the last phase of medical rehabilitation, is an integral part of Sweden's "active labor market policy," which aims at providing a job for everyone. It is open not only to persons with physical and mental handicaps but also to socially maladjusted and disadvantaged persons (juvenile delinquents, ex-convicts, and alcoholics).

Statistics on the total number of disabled in Sweden are not available at this time. The statistics of the rehabilitation sections of public employment offices cover only the handicapped registered with these sections (33,500 in 1961), and include, also, socially maladjusted persons and alcoholics undergoing rehabilitation. On the other hand, these statistics fail to include large groups of handicapped persons.

Since World War II, Sweden has created and expanded its social insurance system covering all resident Swedes and, in most respects, all resident aliens. The mainstays of the system are general health insurance, combined with workmen's compensation and general pension insurance. Of special importance are the liberalized provisions concerning disability pensions, the tax-financed national disability pensions as well as the income-related premium-financed disability pension. A new definition of disability has been adopted and the means test, which formerly determined the amount of national disability pensions, has been abolished. The abolition of the means test benefited in particular disabled housewives whose national pension will no longer have to be reduced in proportion to the husband's income. As a result of the liberalized provisions on eligibility, the number of recipients of disability pensions is expected to increase from the present 140,000 to 170,000 or more.

Due to the extensive social insurance system, Sweden's disabled enjoy a moderate but secure income. However, some disabled persons having no income besides a national disability pension or a daily allowance from health insurance still live in straightened circumstances and municipal social assistance must be added to provide a modest but adequate living level.

Both the municipalities' obligation to give social assistance and the general social insurance system have considerable impact on vocational rehabilitation efforts.

Municipal officers extending social assistance under the auspices of municipal social assistance committees screen the recipients of aid under their care to determine cases which lend themselves to possible rehabilitation. According to the circumstances of each individual case, a handicapped person may be referred to a hospital for medical treatment or given advice on obtaining technical aids to relieve his handicap or be directly referred to the vocational rehabilitation section of the local employment office. In practice, referrals to vocational rehabilitation sections are the most frequent. These municipal services are very important in tracking down patients too listless, ignorant or discouraged to seek rehabilitation on their own initiative, but they are only ancillary to the rehabilitation activities of the Central Government and the counties.

A disabled person should receive disability pension only if rehabilitation has failed to restore his working capacity or to the extent it has failed, the pension supplementing inadequate earnings. By law, a disabled person forfeits his right to a pension if he refuses to submit to the treatment which has been recommended by the agency administering social insurance. While undergoing rehabilitation (medical and vocational), a patient usually receives daily allowances from health insurance. The substitution of a disability pension is usually postponed until the result of the attempt at rehabilitation is known.

The general interest in rehabilitation was significantly increased by the substantial improvement in social insurance benefits and the addition of ATP benefits (supplemental pensions).

The Riksforsakringsverket (National Social Insurance Agency) administers health and maternity insurance, national pensions, disability pensions, and most workmen's compensation. Its most important function in regard to rehabilitation is, however, to direct disabled persons toward the rehabilitation services provided by central and local governments. It has 28 regional subsidiaries called allmanna forsakringskassor, each covering a county or a major city. Attached to each of these regional insurance offices is a joint committee (samarbetslag) consisting of one officer of the division in charge of health insurance, the office's medical adviser, an officer of the provincial labor board, and the same board's medical adviser. All cooperate in this effort.

The committee screens patients afflicted by illness of long duration to determine cases which lend themselves to rehabilitation. Since all adults are entitled to daily allowances for periods of sickness and to free hospitalization, the regional insurance office has a complete record of all cases of illness and their duration. Usually cases are screened when incapacitation has lasted over three months.

A second screening is made by the pension delegations (pensions-delegationerna), one at each regional insurance office (sometimes two and in Stockholm four), when a patient applies for a disability pension.

Treatment and medical rehabilitation is given at general hospitals and at a few specialized establishments administered separately.

Medical rehabilitation clinics preparing the transition from the sickroom directly to gainful employment, or to some phase of vocational rehabilitation, are a relatively new development. Four central county hospitals have been operating such clinics for a few years, others have begun to operate them very recently on a limited scale, and more will follow suit in the next few years. It is hoped that within the next few years each of Sweden's 25 central county hospitals will have a fully equipped rehabilitation clinic. According to the plan of the National Medical Board, a rehabilitation clinic should comprise one section for physiotherapy, one for occupational therapy with facilities for industrial therapy, sections for inpatient and outpatient care, respectively, and one for social counseling and contacts with other agencies, notably those in charge of vocational rehabilitation.

Social counselors (kuratorer) are serving with all major hospitals. One of their tasks is to assemble available information on a patient before referring him to the vocational rehabilitation section of the local employment office.

Since July 1, 1962, the cost of all orthopedic aids (prostheses, supporting braces, surgical boots, crutches, wheelchairs, and other invalid vehicles with or without motor) and repairs of these aids are covered by the Government, provided the aids are obtained upon prescription by a doctor of an orthopedic clinic. Similarly, the Government covers the entire cost of hearing aids for children under 16 years and contributes up to 400 kronor for hearing aids of adults, if the aids are prescribed by ear specialists. The cost of bandages for colostomy and ileostomy and of electric pacemakers for heart patients is defrayed by the Government under special regulations.

Governmental grants are extended through the De Vanforas Riksforbund (National Association for the Care of Cripples), for the purchase of technical appliances.

The coverage of the cost of orthopedic and other aids and appliances is not subject to a means test. Any disabled person is eligible for these benefits, regardless of whether he engages in gainful occupation or has to remain idle.

There is a separate program administered by the National Labor Market Board which provides disabled persons with special technical aids that are needed to engage in gainful occupation or vocational training, e.g. a motor car (as distinct from an invalid's vehicle) and tools for a craftsman.

In the mental hospitals, the program to restore the patient's working capacity is part of the general treatment which aims at readjustment to normal life. Work in sheltered workshops is being tried out on a limited scale. The transition to vocational rehabilitation or placement in a job is prepared by social counselors (kuratorer) who perform similar functions to those in general or specialized hospitals.

Vocational rehabilitation is an integral part of Sweden's labor market and insurance policy. For the central administration of vocational rehabilitation, a Vocational Rehabilitation Division (arbetsvardsbyra) has been created within the National Labor Market Board. An advisory delegation representing other central authorities and certain organizations for the relief of the handicapped has been attached to the Board to ensure the current coordination of governmental measures in this field. The advisory delegation consists of representatives of the National Social Insurance Agency, the National Medical Board, the National Board for Vocational Training, the Central Committee for the Care of Cripples (Svenska Vanforevardens Centralkommittee), and the national organizations of various categories of the handicapped.

On the provincial level, there are vocational rehabilitation sections (arbetsvardsexpeditioner) in the head offices of the employment service (one head office in each of the 24 Provinces and one in Stockholm), and in some of their larger branch offices. These vocational rehabilitation units perform a key role in the system.

The employment offices are administered and supervised by the provincial labor boards, which coordinate their vocational rehabilitation activities with those of the counties.

The counties and the four largest cities have the responsibility for establishing and operating institutions for rehabilitation on the job (arbetstraning, sometimes translated as "work training" or "industrial rehabilitation") and sheltered employment.

Handicapped individuals seeking a job are served by the employment offices' general sections, and only if the section in charge of the applicant's field of employment (e.g. office work) finds it impossible to place him is the handicapped applicant referred to the vocational rehabilitation section.

Only about one-fourth of the vocational rehabilitation section's clients come to it in this manner, however. The remaining three-fourths are referred to it directly from hospitals (through the hospitals' social counsellors), specialized establishments for the care of cripples and other handicapped persons, or by municipal social assistance officers.

The clients of vocational rehabilitation sections include physically or mentally handicapped persons, as well as socially maladjusted persons (ex-convicts, juvenile delinquents, and alcoholics).

If a vocational rehabilitation section finds that a client is in need of training--for instance, in order to specialize in a section of his previous occupation, where his handicap does not impair work performance--or of retraining for a new job, vocational guidance is given either by the rehabilitation officer in charge of the case, or if there is need for specialized advice by the vocational guidance section of the same employment agency. Complicated cases can be referred for aptitude tests to one of the two Institutes for Applied Psychology (in Stockholm and Goteborg).

Any kind of degree of academic education or vocational training is open to the disabled from the simplest manual operation to university studies. The choice in the individual case depends on the client's aptitude, ability and educational background, his age, his prospects for employment and, last but not least, available training facilities.

Whatever kind or method of training is chosen by the client with the advice and assistance of the rehabilitation section, a client without sufficient income receives a trainee allowance from the Government to meet his and his family's essential needs and additional benefits to cover the cost entailed by his participation in training (transportation, working clothes, working material, school supplies, and so forth). The trainee allowances are means tested, which means that they are reduced in proportion to a trainee's income from other sources, including social insurance benefits.

Vocational training can be given at special schools for different categories of the handicapped (the blind, the deaf, orthopedic cases) or at regular vocational schools (operated by municipalities or counties with Government subsidies), or in private industry or public establishments where the clients work as apprentices or trainees.

Rehabilitation on the job (arbetstraning) aims at enabling persons who have been out of work for a long time because of sickness or the consequences of an accident to readjust to work and to contacts with fellow workers in circumstances where allowance is made for fatigue or handicap, inter alia by a reduction of work hours below normal levels.

Sheltered employment is provided for two categories: (1) For persons permanently disabled to a degree which rules out a normal work performance in any conceivable job; (2) for persons who are capable of a normal work performance but would not fit into normal factory or office environment, e.g. because they are seriously disfigured or suffer from a psychic handicap requiring special consideration and patience on employer's or supervisor's part.

Most of the counties operate Vocational Rehabilitation Centers (arbetstranings institute) for rehabilitation on the job and sheltered employment, both categories of clients working side by side in workshops for various kinds of industrial work and in sections for office work. In addition, there are smaller establishments for sheltered employment only, and specialized establishments servicing specific groups of handicapped persons. Besides the counties, sponsors include municipalities, private organizations, and a few industrial companies.

Homework is another very suitable occupation for the seriously handicapped and homework centers are attached to many sheltered employment units. They distribute work orders among the handicapped, collect the finished products, pay for them, and market them. Courses in woodcraft, metalcraft and similar skills are sponsored by the Vocational Rehabilitation Division of the National Labor Market Board.

A third form of sheltered employment is so-called work in archives (arkivarbete) and is administered as part of unemployment relief. This provides employment for elderly or partially disabled intellectuals, many of whom are refugees, for persons with psychic handicaps who require special consideration on the part of the employer, and for others who could not suitably be assigned work in the open market or work involving a physical effort.

A fourth form of sheltered employment, also administered as part of unemployment relief, is _outdoor work for persons who are hard to place_. This is part of the emergency public works program and comprises lighter work in forest and recreation areas or forest work made easy through teamwork for older or partly disabled forest workers and roadbuilding projects for alcoholics or juvenile delinquents.

Sweden maintains an extensive housing and boarding program for elderly persons and the disabled. In addition, the Government extends a subsidy to cover the extra cost of planning and equipping apartments for the specific needs of persons with orthopedic handicaps. The provision of adequate housing is an important link in vocational rehabilitation.

The most important voluntary organizations for the care of the handicapped are the association for the blind, _De Blindas Forening_, for cripples, _De Vanforas Riksforbund_, for the deaf, _Sveriges Dovas Riksforbund_, for persons hard of hearing, _Horselframjandets Riksforbund_, for persons with heart and lung diseases, _Nationalforeningen mot Hjart- och Lungsjukdomar_ and _Riksforbundet for Hjart-och Lungsjuka_, for multiple sclerosis patients, _Svenska MS-foreningarnas Riksforbund_, for polio cases, _Riksforbundet mot Polio_ and for rheumatics, _Riksforbundet mot Reumatism_. In addition, there are associations aiding psychiatric cases, alcoholics, and delinquents.

Political and nonpolitical women's organizations, cooperate in _Kvinnoorganisationernas Stiftelse till Stod at Handikappade Husmodrar_, in order to provide handicapped housewives with special technical appliances to facilitate their housework.

There are four vocational schools for cripples with a total capacity of 247 which are operated with Government subsidies by *Vanforeanstalter* (formerly Institutes for the Total Care of Cripples), whose medical clinics are being incorporated in the general hospital system.

A number of associations are active in the care of cripples and have established the *Svenska Vanforevardens Centralkomittee* (Swedish Central Committee for the Care of Cripples) to coordinate their activities. These organizations are the four institutes for the Care of Cripples, which run the vocational schools described above, the Eugenia Home in Stockholm (for the care of seriously crippled children), the *De Vanforas Riksforbund* (National Association for the Care of Cripples), the associations for polio victims, rheumatics, and multiple sclerosis patients, and the *Svenska Ortopedforneingen* (orthopedic association).

The Swedish Committee of the International Society is the national organization in Sweden affiliated with the *International Society for Rehabilitation of the Disabled* (ISRD).

Summation

The number of applicants registered for vocational rehabilitation rose in 1969. The increase was only 1,797, however, which meant that the sharp rise observable right through the 1960's had come to an end. During the period 1962-1967, the number of applications for vocational rehabilitation increased annually by 7,000-11,000 persons. The 1968 increase was 4,300. The total number of persons seeking vocational rehabilitation in 1969 was 87,901, of whom 50,996 were enrolled during the course of the year.

The production upheavals affecting Swedish industry in 1969 and the resultant closures, rationalizations, and changed attitudes toward older workers seriously affected the chances of handicapped persons to obtain employment in the open market. The opportunities for quick relocation of labor and for placement without any prior preparation decrease year by year.

The importance of all forms of preparatory work is therefore increasing all the time. As a result, the vocational rehabilitation service has had to concentrate more and more on contact work in the different sectors from which applicants are referred to the labor exchanges. Contact work in the nursing, social welfare, prisoners' aid, youth welfare, national health insurance and industrial health service sectors absorb more and more time of vocational rehabilitation officials. Vocational rehabilitation service staff acts as consultants and participate in teamwork efforts in different kinds of rehabilitation and educational work.

Sheltered employment continues to expand at a rapid rate. One result has been to increase the degree of specialization in vocational rehabilitation work. It has become increasingly necessary for vocational rehabilitation service contacts with, for example, the archive work sector, office work centers, sheltered workshops, etc. to be dealt with exclusively by one or more officials.

The Labour Market Board's Vocational Rehabilitation Delegation, which is an advisory body with the function of promoting the coordination of State, municipal and private initiatives in the vocational rehabilitation field, was set up in 1952. At the end of the 1969/70 fiscal year, the Delegation consisted of representatives from eighteen organizations for the handicapped, four government authorities (including the Labour Market Board), five labour market organizations, and three institutions engaged in the care of the handicapped.

The development of the employment service in the direction of a system whereby the individual is provided with the material with which to find a suitable opening for himself, within the limits of the resources available, has probably helped counteract the stream of applications and waiting lists which form for vocational rehabilitation.

Training for the handicapped continues to expand; 16,834 persons started vocational training (including rehabilitation courses) in 1969. In all, 28,724 handicapped or disabled persons underwent vocational training in 1969.

References

1. Fitzpatrick, Thomas K., Rehabilitation Programs and Facilities of Western Europe. U.S. Department of Health, Education, and Welfare, Washington, D.C., 1963
2. "Labour Market Policy," The National Labour Market Board, Stockholm, 1971
3. Leijon, Anna-Greta, Swedish Women--Swedish Men. The Swedish Institute, Stockholm, 1968
4. "Material on Vocational Rehabilitation, Especially on Sheltered Workshops, Organization and Activity," Labour Market Information Series Vl / 1963 (Translation), The National Labour Market Board, Stockholm, 1970
5. "National Labour Market Board," reprinted from the Board's Annual Report, Stockholm, 1970
6. Rehabilitation of the Disabled in Fifty-One Countries. U.S. Department of Health, Education, and Welfare, Vocational Rehabilitation Administration, Washington, D.C., 1964
7. "Swedish Employment Policy," Reprinted from the National Labour Market Board's Annual Report, Stockholm, 1970
8. Taylor, Wallace W., Ph.D. and Taylor, Isabelle W., Ph.D., Special Education of Physically Handicapped Children in Western Europe. International Society for the Welfare of Cripples, New York, 1960

WEST GERMANY

The Federal Republic of Germany (West Germany) was established in Bonn, in 1949. It is composed of 10 Lander or States: Schleswig-Holstein, Hamburg, Lower Saxony, Bremen, North-Rhine, Westphalia, Hesse, Rhineland-Palatinate, Baden-Wuerttemberg, Bavaria, Saarland. The Federal Republic's Constitution also includes the City of Berlin as a state, but this article of the Constitution is under suspension at the present time in order to continue Allied rights to protect the city.

West Germany covers an area of 95,742 square miles. This includes West Berlin. Excluding West Berlin, she has a population of 56,173,207. West Berlin, the largest city, has a population of 2,223,000; Bonn, the capital, has 156,000.

Following World War II, West Germany experienced rapid industrial and economic recovery. She is Western Europe's largest steel producer and has a high rate of production of iron ore, pig iron, ferroalloys, coal, and a large oil refining capacity.

Statistics indicate that in 1961, there were approximately 800,000 severely disabled persons, that is, with physical handicaps limiting their earning capacity by 50 percent or more, including 656,000 war victims and 145,000 persons who suffered work accidents. It is possible that there are some additional 100,000 to 150,000 persons with severe physical handicaps as the result of illness, other than work accidents or congenital defects, but accurate data on these are not available. However, the number of severely disabled persons reported by labor exchanges as unemployed had been reduced to 6,000 by 1960, and may have declined further in view of continuing overemployment into the '70s.

Rehabilitation was supported by private initiative in Germany as early as the 19th century; a hospital for the medical treatment and education of deformed children was established by a German physician in 1823. Churches supported many of these early activities. By the 20th century a few outstanding orthopedists were defining rehabilitation as all services necessary to return the disabled to his place in society and these concepts are being implemented in some hospitals up to the present time.

Following World War I statutory provisions (1920) for the rehabilitation and relief of the war disabled and their dependents, incorporated the philosophy of medical restoration and training or retraining for suitable employment. After World War II, under the Federal Republic, these laws were adjusted to changed conditions, amended and extended. The laws distinguish between the heavily disabled and the physically handicapped. Employment potential is the goal, if possible.

Due to the vast needs of the war disabled in Germany and the importance and relatively advanced development of orthopedics as a medical specialty, great emphasis was placed on medical, mostly orthopedic, rehabilitation after World War II. Even greater development of this medical specialty resulted.

In West Germany there is a variety of social security provisions under the general supervision of the Federal Ministry of Labor and Social Affairs. A Federal law, enacted in 1950, and administered by the Ministry of Labor and Social Security, provided for medical treatment, pension benefits, social counseling, vocational training, and assistance in job placement for the war disabled. Hospitalization and outpatient clinic treatment, prosthetic appliances, orthopedic shoes, etc. were also available under the law, as well as grants for the purchase, alteration, and maintenance of vehicles.

The Ministry appointed a special council on Orthopedic and Vocational aids which conducts research work in the manufacture of braces and artificial appliances under special conditions, i.e., at the University of Munster, the Technical University of Berlin, the Max Planck Institute at Dortmund, and the Federal Institute at Frankfort on Main. Training in the use of prosthetic and orthotic appliances is provided for centers operated under public and voluntary auspices.

Salaried employees (within a specified maximum) and wage earners receive old age, invalidity, and death benefits under employee-employer Government contributory programs (1963 amendment of 1911 law). This program is administered by State or Federal Insurance Offices.

Employed persons and certain categories of self-employed are covered under a work-injury program (1963 amendment to 1911 law) supported by contributions by employers. Benefits include medical care, appliances, and retraining. Unemployment benefits (current law 1956) for employees in private employment are provided in a program supported by contributions from employees and employers, administered by the Federal Placement and Unemployment Insurance Institute.

Rehabilitation of persons disabled by work accidents, road accidents, and occupational diseases are protected by statutory Accident

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Insurance Associations that provide for as complete rehabilitation as possible. These associations maintain working arrangements with over 1,000 hospitals.

The law governing war victims' benefits provides the basis for vocational training, advanced training or retraining. Such training is offered in open courses, seminars, training in schools and on the job. The labor exchanges evaluate the fitness of the individual for the selected occupation. In addition, Accident Insurance Funds, under the work-injury legislation, are used for the rehabilitation of persons with incapacities resulting from work-related accidents or disease.

The Federal Labor Placement Institute has the overall responsibility for work placements and is required by law to take such job and vocational training measures as are required for the maintenance, improvement, and restoration of employment capacity of a mentally or physically handicapped person in order to integrate job seekers and training applicants into the employment process. Each labor exchange, under the State Labor Office in each State, has a special placement agency for the disabled. This agency has available psychological and technical services, information on available jobs and job requirements and makes regular contact with employers. Employers are committed by law to make a percentage of jobs available to heavily disabled persons and to make placements which enable full use and further development of their abilities and knowledge (maintenance of plant facilities, machines, tools, plant operation).

Due to the conviction that the handicapped should take their place in society and compete with the nonhandicapped and not be isolated in their working lives, there are no State supported factories or sheltered workshops. Most rehabilitation centers are for training. Rehabilitation centers where the severely handicapped obtain permanent employment because they cannot get work in the open market receive aid from the State in the form of work orders.

The majority of work done in the Federal Republic in rehabilitation and services to the handicapped is financed by the Government or employer-supported accident insurance agencies working cooperatively. Nevertheless, there are both national and local associations concerned with the welfare of the disabled. For example, the German Federation of the Blind and the German Union for the Deaf are central organizations with regional, State or local units; denominational efforts are coordinated by the Federation of German Evangelical Institutes for the Physically Handicapped and the Federation of Catholic Institutes for the Physically Handicapped. Concern for specific aspects of disability is evident in the German Association for the Control of Crippling, the National Association for War and Civilian Disabled, the Association for War Veterans, the German Association for Multiple Sclerosis, and the Association of Polio Victims and their sponsors.

All federations and associations for self-help are incorporated members of the German Federation for the promotion of the Welfare of the Physically Handicapped. This organization serves to coordinate and promote means to prevent, eliminate, and ameliorate physical disabilities and their consequences. It works cooperatively with the Government to improve and expand services.

Summation

By law, war victims may claim the application of measures to promote employment (Federal Act of 20 December 1950 on assistance to war victims--Act of 16 June 1953 on the employment of disabled persons).

Under the war victims assistance scheme (Federal Act of 1950 on assistance to war victims, as amended by the Second Reorganization Act of 21 February 1964--Bundesgesgesetzblatt I, page 750), persons suffering from injuries incurred on military or para-military service, or as a result of the conditions inherent in such service, or as a direct consequence of war, are entitled to curative treatment, which includes medical and dental treatment, outpatient treatment, the supply of medicines, dressings, remedies and dentures, hospitalization, treatment in a sanatorium (for tuberculosis), care provided by nurses and other medical auxiliaries (treatment and care at home), and the provision of orthopedic appliances. The nature and extent of the curative treatment are identical with the benefits supplied to their members by sickness insurance funds, unless the Act on assistance to war victims provides otherwise.

The Employment Promotion Act of 25 June 1969, which entered into force on 1 July, instructs the Federal Labour Office of the Ministry of Labour and Social Affairs to coordinate rehabilitation work by making use of its specialized services and of the network of regional offices affording direct access to the labor market.

It may provide assistance either in the form of benefits to individuals or in the form of collective assistance (establishments and sheltered workshops).

The Disabled Person's Employment Act (Schwerbeschädigtengesetz) of 16 June 1953 contains special provisions applicable to war victims:

-- Steps must be taken to ensure that sufficient numbers of war blinded are included in the compulsory categories.

-- When female posts are being filled in the public services priority may be given to widows of military or of civilian war victims of service--men posted as missing, or of prisoners of war. The wives of disabled persons who are unable to work enjoy this same advantage.

The statutory accident insurance institutions are responsible for rehabilitation measures, i.e., medical treatment (functional rehabilitation) and the occupational and social rehabilitation of industrial accident victims (occupational assistance). The Industrial Accidents Act of 1884 already provided that accident insurance corporations were responsible for providing appropriate curative measures, and the amending Acts of 1892, 1900 and 1925 supplemented and widened the scope of the relevant provisions.

Measures designed to maintain, improve or restore earning capacity, usually designated by the term "rehabilitation," are governed by the Reich Insurance Code, the disablement and old-age insurance scheme for workers, the employees' disablement and old-age insurance scheme and the miners' scheme. The basic idea underlying these measures is that it is more sensible and more profitable, both for the insured and for the community as a whole, to restore his health and his occupational capacity than to pay him a pension.

The order of 13 February 1924 on Welfare Services and the Reich Directives of 4 December 1924 concerning the conditions for the nature and scope of public assistance provide for the reclassification of all needy cases, including physically and mentally handicapped persons not covered by an insurance scheme. The Disabled Persons Act of 27 February 1957 prescribes measures for the rehabilitation and re-education of persons suffering from a defect of the motor or sympathetic systems, or in danger of so suffering; such measures include curative treatment, the supply of orthopedic appliances, education and occupational training, as well as welfare and follow-up services.

In pursuance of the Employment Promotion Act of 25 June 1969, which entered into force on 1 July 1969, considerable improvements are now being made to individual and collective arrangements for the rehabilitation and placement of disabled persons.

The Federal Office is now also authorized to provide assistance to sheltered workshops in the form of loans and subsidies. This arrangement will be of benefit to disabled persons who are not yet, or never will be, capable of finding open employment.

An Act on the employment of disabled persons, passed by the Federal Parliament on 16 June 1953 with retroactive effect to 1 May 1953, is mainly designed for the reintegration of war victims into working life. The scope of this Act was broadened and the provisions improved in 1961.

The Act on the employment of disabled persons - new version of 14 August 1961 - requires employers to assign to disabled persons:

(a) 10% of posts, if public authorities

(b) 6% of posts, if public or private undertakings

Any employer under sub-paragraph (a) employing more than nine persons and any employer under sub-paragraph (b) employing more than fifteen persons must take on at least one disabled person.

A private employer who fails to give employment to the number of disabled persons prescribed for his undertaking or to comply to the fullest with his employment obligations, will be liable to a fine of 50 Dm monthly for each reserved post unfilled. The amount of the fine is fixed by the employment office and is paid by the employer to the principal assistance office (Hauptfürsogestelle). The fine may be reduced or waived in critical situations; for example, if, in spite of his efforts, an employer is unable to fulfill his obligation to employ disabled persons.

The proceeds of fines are used for promoting the employment of disabled persons, as well as for the recovery and maintenance of their working capacity and for financing the development of rehabilitation centers.

The Act on the employment of disabled persons also provides for the following preferential treatment of the persons protected by it. No employer may dismiss a disabled person without the authorization of the principal assistance office. Disabled persons are entitled to six additional working days of paid leave per annum. Employers must give disabled persons work which they can, as far as possible, use to the fullest in development of their abilities and knowledge.

Occupational rehabilitation and re-education are organized by a number of autonomous statutory bodies under the control of various government departments, such as the Federal Ministry of Labour and Social Affairs, the Federal Ministry of the Interior, the competent Lander departments and the Federal Insurance Board.

Foremost among the institutions which act as rehabilitation centers, i.e., which cater to medical, vocational and social needs, is the Federal Bureau of Labour and Unemployment Insurance. Its task is to give advice to any person, either fit or disabled, seeking employment or guidance.

It should be pointed out that as a result of discussions in parliament on the Employment Promotion Act, the funds made available to assist rehabilitation centers working on a federal scale and prevocational retraining centers have been substantially increased (6).

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References

1. Braun, Heinrich, Rehabilitation of the Disabled in Germany. Gesemtherstellung: Merkur-Druckerei GmbH, Spich Bez. Kölm, Germany, 1966

2. "Eurodidac-bulletin," Freiborg-Ebnet, Dutschland, January, 1971

3. Fitzpatrick, Thomas K., Rehabilitation Programs and Facilities of Western Europe. U.S. Department of Health, Education, and Welfare, Washington, D.C., 1963

4. Köllermann, Hans W., Social Policy in Germany - A Systematic and Historical Introduction. Federal Ministry of Labour and the Social Structure, Druckhaus Sachsenstrasse, Essen, 1967

5. Ibid., Social Legislation in the Federal Republic of Germany. Asgard-Verlag GmbH, Bonn-Bad Godesberg, 1970

6. "Partial Agreement in the Social and Public Health Field," Joint Committee on the Rehabilitation and Resettlement of the Disabled, Council of Europe, The Federal Republic of Germany, June, 1969

7. "Rehabilitation-Auftrag Und Verflichtung," Reichsbund, Bonn-Bad Godesberg, Im Marz, 1970

8. Rehabilitation of the Disabled in Fifty-One Countries. U.S. Dept. of Health, Education, and Welfare, Vocational Rehabilitation Administration, Washington, D.C., 1964

9. Schopper, Hans, "Elektro-Bailler" (Lehrgerät, Arbeits-Und Kommunikationsmittel) für Blinde Und Taubblinde in Schule Und Beruf, Landesschule für Blinde, 8 München 19, Marie-Ward-Stra Be 41, June, 1971

10. Taylor, Wallace W., Ph.D. and Taylor, Isabelle W., Ph.D., Special Education of Physically Handicapped Children in Western Europe. International Society for the Welfare of Cripples, New York, 1970

11. Zöllmer, Dr. Detlev (Von Regierungsrat), Prävention Und Rehabilitation. Druck: Druckerei Hachenburg GmbH., Hachenburg, Juli, 1962

12. Vom, Herausgegeben, Die gesetzlichen Grundlagen de Rehabilitation in der Bundesrepublik Deutschland - Schriftenreihe Des Reichsbundes, Folge 23, Mai, 1964

PART III

Vocational Rehabilitation and Facilities in the United States - A Model

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Vocational Rehabilitation and Facilities in the United States -- A Model

Introduction:

It has been said by experts in rehabilitation that "a civilization may be measured in some degree by the treatment accorded the disabled members of its society." Among certain past civilizations, such practices as putting the disabled to death or "locking them away" were followed. Even in this country, the disabled have not always been accorded the best treatment. However, in our times, their talents are being recognized, and they are being brought "out of the closets" and "off the shelves" and through the doorways to opportunity which has been opened by a more enlightened and informed citizenry (Peters, 13).

For the past dozen or more years rehabilitation facilities have been engaged in rehabilitation of the severely and other physically disabled citizens. Many have adopted the concept of Vocational Rehabilitation similar to those found at Johnstown, Pennsylvania and Fishersville, Virginia. Some of these centers are publicly or state operated, and some are private or non-profit. Unique features of all of them are their emphasis on pre-vocational and vocational residential training, medical restorative, etc. services and supervision, and personal and social adjustment.

At a greatly accelerated pace over the past few years, the Congress of the United States has enacted new legislation designed to assist physically, mentally, emotionally, educationally and culturally handicapped citizens in their efforts to achieve a dignified, decent life. Such legislation has re-emphasized the need for evaluating and diagnosing rehabilitation potential prior to and/or during training for re-entering the job market. In many instances, for example, work with the mentally retarded or cerebral palsied, the problem becomes one of habilitation. Rehabilitation and habilitation are not mutually exclusive, they are products of the same culture medium.

The Vocational Rehabilitation Act Amendments (P.L. 89-333) passed by the Congress in 1965, and amendments to the Social Security Act (1957 and 1960) greatly strengthened the States' Vocational Rehabilitation programs by making more money and personnel available. In Connecticut, for example, the program quadrupled in size over a period of about five years. The grants-in-aid programs to workshops and rehabilitation facilities enabled the States' Vocational Rehabilitation programs to utilize more funds for patients needing help through rehabilitation facilities. Such rehabilitation concerns itself with the whole person; his medical, social, emotional and, last but not least, vocational needs (Cull and Hardy, 4).

The increase of disability among the general population of the United States is probably proportionate to some degree to the growing extent of mechanization in our culture with resultant industrial accidents. Of no less importance is the ability of the medical profession to increase life expectancy through the miracles of modern day drugs, surgery and rehabilitation. Disability, then, has affected greater numbers of individuals and left them with varying degrees of handicap for a productive life. This goes for the aging and the young also, especially for those young people caught up in the "drug culture."

Each year in the United States some 3,715,000 persons between 17 and 64 years of age, who usually work, become limited in the amount or kind of major activity by one or more chronic conditions. This is equivalent to a rate of 2,040 per 100,000 of the general population. The proportionate total for Connecticut (based on 1962 census) is 54,500. This indicates that there is a need in our State to vocationally rehabilitate over 50,000 disabled persons per year. This figure will double over the next decade. The comprehensive and other types of rehabilitation centers must play a large role in helping our State to cope with this problem. This is equally true of the forty-nine other States in our country. A look at some model programs across the country is, hereby, indicated.

- Federal Program -

The Department of Health, Education, and Welfare is an organization of people serving people--the more than 200 million Americans. In one way or another, the Department touches the lives of almost every person in the United States. In fact, HEW comes closest of all Federal agencies to achieving a major constitutional aim of our Government: "to promote the general welfare." By working to release human potential and eradicate demeaning conditions that stunt dignity, growth and development, the Department strives to help all Americans build healthier, happier, and richer lives.

Essentially, HEW helps people solve problems. Through its more than 250 programs authorized by the Congress, the Department's 107,000 specialists in more than 300 different occupations try to help people overcome obstacles too enormous for them to cope with alone.

These challenges include:

- The treatment and study of disease, particularly such major killers as heart disorders, cancer and stroke.
- Controlling communicable diseases and eradicating epidemics.
- Increasing the nation's supply of hospital beds and qualified physicians, dentists, nurses, social workers, rehabilitation specialists, and allied health personnel.
- Providing rehabilitation services to the physically and mentally disabled.
- Making sure that quality health services are available to all people.
- Controlling occupational health hazards.
- Inspecting foods and drugs to determine whether they are pure and safe.
- Alleviating the effects of mental retardation and mental illness.
- Improving the quality of education in the country's elementary and secondary schools.
- Reducing the social and educational handicaps of poor children.
- Expanding and improving libraries.
- Providing basic education and vocational training to adults who cannot compete in the labor market.
- Making college and graduate school available to more people.

- Providing aging citizens financial security and better medical care.
- Offering assistance to people unable to work.
- Conducting research in a variety of social problems.
- Eliminating denial of equal health care and educational opportunity to any segment of our society.

The basic Federal-State program of vocational rehabilitation began in 1920. Since then, more than two and one-half million people have been successfully rehabilitated. The program of basic support grants to States focuses on the individual disabled person, his abilities and aptitudes, his interests, and his needs. In many States there are two programs--one for people who are blind and one for people with other disabilities.

The Federal-State funding pattern also provides for special research and demonstration projects in rehabilitation, innovation and expansion projects, career training in the rehabilitation field through training and initial staffing grants, and grants for construction of rehabilitation facilities and facility planning.

The Rehabilitation Services Administration also focuses on another key group--the mentally retarded. Programs benefitting the retarded include hospital improvement and modernization, community facilities construction and staffing, and special rehabilitation services for the retarded.

For more than 30 years, RSA has administered a program under which blind persons are licensed to operate vending stands on Federal property. State rehabilitation agencies provide training and retail services to prepare blind persons for the work and supervise stand operations. There are more than 2,800 stands providing employment for more than 3,000 operators, who average more than $5,200 a year in earnings (11).

- Regional -

The Division of Rehabilitation Facilities, Rehabilitation Services Administration, is issuing a National Directory of Rehabilitation Facilities. The directory consists of ten volumes, one volume for each region of the U.S. Department of Health, Education and Welfare.

Volume VIII, for Region VIII, catalogues vocational rehabilitation facilities which the Colorado, Montana, North Dakota, South Dakota, Utah and Wyoming State Rehabilitation agencies utilize for client services. The information found for each facility was taken from State facilities plans or from information which State facilities planning supervisors supplied to the Division of Rehabilitation Facilities. The names and addresses of State facilities planning supervisors for Region VIII are found in the appendix.

The information presented for each facility should not be considered complete as additional information will be included in the revised issue of the directory for Region VIII. State facilities planning supervisors will be in touch with executive directors and administrators of facilities for more information or for up-to-date information that will be included in the annual modifications of State facilities plans and for inclusion in future issuances of the directory and other publications of the Division of Rehabilitation Facilities.

Executive directors and administrators of facilities that are not listed are advised to either telephone or write their State facilities planning supervisor for information concerning listing in the directory (9).

- State of Connecticut -

Division of Vocational Rehabilitation

How Vocational Rehabilitation Serves the Disabled.

What is Vocational Rehabilitation?

Vocational Rehabilitation is a public service for developing and restoring the working usefulness of handicapped persons so that they may become self-supporting.

Who is Eligible for Help?

Any handicapped individual who can be reasonably expected to profit by rehabilitation services may apply for rehabilitation assistance. Disabled veterans are eligible to the extent that they are not entitled to or are not receiving similar benefits through the Veterans Administration.

Persons with disabilities resulting from birth, disease, accident, from emotional or behavioral causes are served. These disabilities include arm and leg deformities, amputations, heart ailments, tuberculosis, hearing, speech and eye defects, mental illness, environmental, and other handicapping conditions. Services are provided without regard to race, color, creed, or national origin.

What Services are Provided?

1. Full evaluation, including medical diagnosis, to learn the nature and degree of disability and to help evaluate the individual's work capacity.
2. Counseling and guidance in achieving good vocational adjustment.

3. Medical, surgical, psychiatric and hospital care and related therapy to reduce or remove the disability.
4. Artificial limbs and other prosthetic and orthotic devices needed to increase work ability.
5. Training, including training for a vocation, pre-vocational and personal adjustment training, and remedial education.
6. Service in comprehensive or specialized rehabilitation facilities, including sheltered workshops and adjustment centers.
7. Maintenance and transportation when necessary so that the disabled person may get full benefit of other vocational rehabilitation services.
8. Tools, equipment, and licenses for work on a job or in establishing a small business.
9. Placement in a job suited to the individual's highest physical and mental capacities.
10. Post-placement follow-up to see that placement is satisfactory to both employee and employer.

How Do Disabled Benefit?

Services are provided to meet the individual needs of disabled persons so that they may engage in safe and suitable occupations.

Such services are provided at public expense.

Many physical or mental handicaps can be removed through vocational rehabilitation services. Others may be corrected to the point where they do not interfere with work demands of properly selected jobs. Employment records of thousands of vocationally handicapped persons prove: It's not what a man has lost, but what he has left that's important.

How Do Employers Benefit?

Rehabilitation services available without cost to employers include:

1. Counseling to conserve manpower.
2. Evaluation of capacities of handicapped applicants.
3. Aid in restoring and retraining injured workers.
4. Advice in determining suitable jobs for disabled personnel.
5. Referral of trained, skilled, reliable workers who have benefitted from rehabilitation services.

How Do You Apply?

By phone, letter, or personal visit. An appointment with a rehabilitation counselor can be arranged at the nearest local office of your State Rehabilitation Agency, or at some other location convenient to you. After consultation, your rehabilitation counselor will determine with you what services may be needed in your particular case.

For blind individuals, services are provided by The Board of Education and Services for the Blind (5).

MODEL A

The Easter Seal Society
Easter Seal Rehabilitation Center
2757 Telegraph Avenue
Oakland, California 94612

The Alameda County Easter Seal Rehabilitation Center features a comprehensive program for patients that includes physical, speech and occupational therapy, social service and employment guidance, medical direction and evaluation, nursing and homebound therapy.

Referrals to the Rehabilitation Center are made by any licensed physician or dentist. There are no restrictions as to age or diagnostic group, except that the disability must be primarily physical rather than mental.

Among the valuable equipment recently acquired is an electromyograph, a complex instrument that detects muscle and nerve diseases in physically disabled patients.

Another important feature is the therapeutic pool that assists patients with such problems as a hip fracture, arthritis or low back syndrome.

For the patient with an amputation, the Center offers an amputee clinic, the only private, non-governmental amputee service in this area. The clinic is a team approach to the total needs of the patient that includes the consulting physician, prosthetist, therapists and a social worker.

All Center services are often used for the stroke patient. There is rehabilitation medicine consultation, speech therapy if the patient is aphasic, occupational therapy for activities of daily living,

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physical therapy for exercise and gait training and social service for patient and/or family.

Any physician interested in using the equipment and services mentioned has only to call the Rehabilitation Center for further information at 835-3131.

The Alameda County Society, an affiliate of the California and National Easter Seal Societies for Crippled Children and Adults, serves all persons regardless of age, cause of crippling, race, religion or economic status (3).

MODEL B

Las Palmas School for Girls
1500 South McDonnell Avenue
Los Angeles, California 90022

Las Palmas functions as a residential treatment center for 100 adolescent, delinquent girls between the ages of 13 to 18 years, of every religion, race, or nationality. The Agency is used exclusively as a placement facility for girls who are wards of the Los Angeles County Juvenile Court under a Delinquency Subdivision, and for whom an Order of Suitable Placement has been made. While these girls come to the attention of the courts because of delinquent behavior, they are youngsters with unstable personalities characterized by hostile, aggressive, impulsive acting-out behavior.

Girls accepted for care must be between the ages of 13 to 17½ years at the point of intake. Girls with serious physical handicaps, or who are diagnosed as psychotic, or sociopathic are not accepted. Practically all the girls accepted for placement can be described as falling within the range of the character or behavior disorders. Clinical studies indicate these character disorders range from those which tend to be more neurotic to those which border on the sociopathic. Most girls in placement have been involved in any one of a number of the following types of behavior: drug abuse, runaway, sex delinquency, truancy, incorrigibility, shoplifting, car theft, etc.

Once a girl has undergone the treatment program at Las Palmas and has been released into the community, she may later return to the institution as a resident in order to receive additional assistance. There are also non-resident pupils at Las Palmas. Because these girls have had difficulty adjusting to the community schools, they are permitted to attend school at Las Palmas but reside off campus. There are usually between two and four students who attend Las Palmas School in this way (7).

MODEL C

San Francisco Aid Retarded Children, Inc.
1362 - 9th Avenue
San Francisco, California 94122

Adult Vocational Program

The primary goal of everything we do at Aid Retarded Children is aimed at the development of a community awareness about the nature of those children and adults who have mental retardation.

We know that if the citizens of San Francisco know those who are mentally retarded, the programs and services which are extended to most members of the community will be extended to the retarded members as well.

We at Aid Retarded Children have made it our responsibility to become a part of our city, serving on committees, offering the expertise of volunteers and staff and conducting demonstration projects which will help prove our contention - that the retarded can be full-fledged members of society.

Thirteen years ago there was a prevalent belief that seriously retarded persons could not be trained to hold down jobs. Aid Retarded Children started a Work Training Center. The year, 1956. There were 30 young men and women in the pilot project. At its conclusion the State Department of Rehabilitation agreed to accept our clients as people who could be trained to work.

The San Francisco Community Rehabilitation Workshop, resulting from a joint-planning venture with other voluntary health associations, is further proof of the retarded persons ability to perform successfully (1).

MODEL D

Area C
Community Mental Health Center
Department of Human Resources
Washington, D.C.

Area C Community Mental Health Center, June 1966-Summer, 1968

In June 1966 there were still two separate and distinct psychiatric services on the grounds of D. C. General Hospital. The older service was the Acute Psychiatry Service, housed in the newer, larger building. The service itself had strong ties with Georgetown University's Department of Psychiatry and its teaching staff for psychiatric residents. Its services were available to persons suffering from all types of psychiatric problems in the District of Columbia and especially those in areas outside Area C. The acute service did offer specific facilities to certain Area C patients, such as an inpatient facility for children and adolescents and some of the more acute alcoholic patients.

A long established mental health clinic in the Northeast Section of the catchment area, had been designated a satellite of the newer Area C Community Mental Health Center. It has served children and adolescents and their parents and guardians in the immediate geographic area as well as some families in other health areas. With its change in title it began to limit its services to Area C residents within Statistical Area 14 in which it was located.

While the staff of the newer service, Area C Community Mental Health Center, was involved with the internal complexities of what had happened, what was happening and what would happen in the future, outside of the walls other events were occurring. The Health Department actively sought a replacement for its Area C Center director, both within its program and in other parts of the country. A psychiatrist from the Adult Program was finally selected as Acting Director of the Center. She was later appointed Director.

Altogether, internal and external pressures exerted considerable influence on the Center during this difficult and growing period. Several adult units in the Acute Psychiatry Service were transferred to the Adult Program. This was followed by an organizational change in which the Acute Psychiatric Service was transferred from D. C. General Hospital to the Mental Health Directorate. With the transfer to the Mental Health Directorate other inpatient changes resulted in Area C Mental Health Center. Programs with large city-wide outpatient rosters were directed to discharge patients from all areas except C while the Northeast Satellite would specifically concentrate on patients from the surrounding Statistical Area 14. Services and units within

Acute Psychiatry were also reorganized. Units were specifically designated to serve the other three health catchment areas in the city (2).

MODEL E

The Gaylord Hospital
Wallingford, Connecticut

Gaylord Hospital has determined to fill the now vacant role of pacesetter, a model for the national reawakening to the importance of rehabilitation. It has placed great emphasis on the quality of rehabilitation. The hospital has 100 beds, a staff of 254 and treats approximately 500 patients each year. The work being done here is not likely to clear away the national backlog of those in need of rehabilitation. Nonetheless, Gaylord, as one of the leading rehabilitation centers in the east, as one of the historic innovators in the field, as an institution whose commitment to rehabilitation is total and deep-rooted, must show the way. And its role of national leader in the field is a particularly critical one to the State of Connecticut. Gaylord's patients come chiefly from within the State. They include victims of stroke and aphasia, multiple sclerosis, muscular dystrophy, arthritis and tuberculosis as well as paraplegics (those paralyzed from the chest down) and those recovering from heart attacks, amputations or other surgery. Each is treated as a whole patient and receives--in addition to medical and nursing care of all kinds--psychiatric counseling, vocational and occupational testing and evaluation, and physical therapy (14).

MODEL F

Pennsylvania Rehabilitation Center
727 Goucher Street
Johnstown, Pennsylvania

The Pennsylvania Rehabilitation Center is operated by the

Pennsylvania Bureau of Rehabilitation. The Bureau is part of a State-Federal program to provide rehabilitation services for the disabled. It is tax supported and is one of the few such programs which actually results in tax savings in that a rehabilitated person pays back in taxes the cost of his rehabilitation within three to four years.

Construction of the 348-bed center began in 1956 after more than two years of planning. It was completed in 1959 at a cost of over $8,000,000. It is located on approximately 35 acres of land. The buildings cover more than 8 acres. The rest of the area is devoted to outdoor recreational activities.

This is a comprehensive rehabilitation center which offers: A. Medical, B. Psychosocial, C. Vocational Services

Medical Services
(48-Bed Medical Wing)

A. General Medical Supervision
B. Special Medical Consultation
C. Rehabilitation Nursing
D. Physical Therapy
E. Occupational Therapy
F. Speech Therapy
G. Laboratory and X-Ray

Psychosocial Services

A. Counseling
B. Psychological Testing
C. Vocational Evaluation
D. Social Casework
E. Family Counseling & Guidance
F. Supervised Recreational & Social Activities

Vocational Training

A. Appliance Repair
B. Arts & Crafts
C. Baking & Cooking
D. Brace Making
E. Business Education
F. Cabinet Making & Finishing
G. Dental Lab. Technician
H. Distributive Education
I. Drafting Technology
J. Dressmaking & Sewing
K. Electronics
L. Instrument Technology & Related Subjects
M. Laundry
N. Library
O. Medical Specialties
  Nurses Aide/Orderly
P. Motor Repair & Related Subjects
Q. Office Machine Repair
R. Printing Technology
S. Shoe Service Trades
T. Tailoring
U. Upholstery
V. Cooperative Training Program (12)

MODEL G

National Urban League, Inc.
55 East 52nd Street
New York, New York 10022

On-The-Job Training, a program developed by the National Urban League in cooperation with and funded by the U.S. Department of Labor, was organized in 1964 to seek out and develop training opportunities for unemployed members of minority groups.

The National Urban League, seeing a need for placing greater emphasis on the plight of the unemployed, the under-employed and those who have lost their jobs because of technological changes, has expanded its original purpose. OJT not only recruits the disadvantaged job seeker, we retrain him so he may upgrade himself and we train him so that he may reach his maximum level of job performance.

While we work to alleviate severe unemployment and under-employment, we help the employer-trainer to fulfill his manpower needs.

Urban League OJT is the most successful on-the-job training program today. Five years ago OJT operated in four cities. Today it is successfully operating in thirty-two cities. Of the 36,000 placements we have made since 1964, 89 percent have successfully completed training and have been hired on a full-time basis.

1. A field representative of the National Urban League will discuss your manpower needs and the possibility of job training opportunities for minority job seekers who are unemployed or underemployed, the underemployed being those who work hard but cannot earn enough to support their families.
2. Training officers of the National Urban League will counsel potential trainees before they go into OJT and will conduct follow-up counseling sessions after the trainee is placed.
3. Trainee advisers of the National Urban League will recruit, interview, and screen applicants, referring them to job training opportunities in line with their interests and abilities.
4. The OJT program trains for jobs and promotions in private industry that are readily available, rather than creating jobs with Federal subsidies.
5. Although the Urban League OJT project staff will handle paperwork and the basic processing of trainees, you reserve the right to make the final selection and to design the training sequence to meet your needs. Upon acceptance by your firm, the trainee becomes an employee enjoying the same

responsibilities, privileges and benefits as other employees. In addition, Urban League training officers are available for on-the-spot counseling whenever necessary (10).

MODEL H

Institute for the Crippled and Disabled
400 First Avenue
New York, New York 10010

The Vocational Rehabilitation Program at ICD

ICD's Vocational Rehabilitation Services include evaluation, counseling, training and placement. The TOWER System, an ICD development, is used for measuring vocational potential and determining the selection and assignment of Workshop clients. Training includes jewelry manufacturing, machine shop operations, optical mechanics, electronics, business machine operation, general clerical skills, pantograph engraving, food handling, mailroom and messenger work.

The principal function of Industrial Rehabilitation at ICD is the operation of a sheltered workshop for 200 physically and/or emotionally handicapped persons not ready to undertake competitive employment. Workshop clients receive a preliminary job evaluation and personal adjustment training to develop work habits, work tolerance and productive speed for trade training and/or placement in industry.

ICD's Comprehensive Program

Medical, Social Adjustment and Prosthetic and Orthotic services are integrated with vocational rehabilitation at ICD to provide a comprehensive program of outpatient services for the physically and emotionally disabled.

Clients are referred to ICD by State vocational rehabilitation agencies, community agencies, insurance companies, State mental hospitals, private physicians and many other sources. Clients range in age from young children to adults in advanced years.

In addition to outpatient services, ICD offers a broad professional education program. Basic medical studies relating to rehabilitation are conducted by the Milbank Research Laboratories, operated jointly with New York University Medical Center (16).

MODEL I

Morgan Memorial, Inc.
Goodwill Rehabilitation Centers
95 Berkeley Street
Boston, Massachusetts 02116

At the New England Rehabilitation-For-Work Center all programs, however different from one another, have evolved within a single framework characterized by three primary features:

1. A client-centered outlook
2. A respect for the client as a whole person
3. An orientation to optimal functioning

Although the project was established with identification of interest in meeting the needs of persons characterized by particular types of disabilities, the actual implementation of client services occurred, always, with respect to the needs of individuals. The fact that a large percentage of the caseload was comprised of visually impaired persons was a useful statistic for certain kinds of research. However, it was of only incidental relevance for the conception and administration of programs for individual clients. Some consideration had been given to the value of establishing a fixed curriculum within

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which all clients would be assigned, but this idea was discarded as being inconsistent with the facts of individual differences and with the desire to respect the integrity of Center clients. Allied to the notion of a fixed program was the use of a class-like admission schedule. This had been an operating characteristic of the pre-project Noyes program in which a group of clients was admitted at fairly regular intervals. This practice may have facilitated the evaluation of certain group dynamics, but the value of individualized admissions which were adopted with the inception of the project was borne out repeatedly on those many occasions when a client was referred with the expression that "a delay in getting him started would be disadvantageous."

Too much research and demonstration had preceded the initiation of this service-oriented rehabilitation center project to permit anything other than a multidisciplinary approach to programming. In addition to the concern for services being planned around the needs of clients as individuals, the staff was also mindful of the fact that these needs were usually multiple and were far from limited to the area of work skills. More frequently than not, it was apparent that personal-social maladjustment was not only causing more immediate problems than were any vocational deficiencies but also constituted themselves basic obstacles to efficient functioning in any endeavor, be it scholastic, vocational or social.

Since over 90% of Center clients were in fact not "ours" but were referred by State or Federal agencies for what amounted to consulting service only, it was often very difficult to extend the breadth and depth of staff interest in the clients. The limited extent to which they were able to become involved in the home and family situation of clients was a case in point (15).

MODEL J

American School for the Deaf
139 North Main Street
West Hartford, Connecticut 06107

The Graham H. Anthony Vocational Rehabilitation Center

The Graham H. Anthony Vocational Rehabilitation Center is operated by the American School for the Deaf on the school campus and furnishes vocational evaluation, training, placement, and follow-up services for both hearing-impaired youth and adults.

"A Key to the Quest for Meaningful Employment"

The Center operates on the sound philosophy that evaluation is "A Quest for Potential," that rehabilitation is a "key for the quest for meaningful employment" and that every individual can achieve a satisfactory life vocation if proper structure is provided. This is done by reinforcing as many reality variables as possible.

Program

The Center provides for routine inter-staff communication between vocational rehabilitation, vocational education and training, audiological, life adjustment, counseling, placement, follow-up and related services.

Vocational Training

Thirteen vocational departments offer training in the following areas:

Auto Body

Business Education

Tool and Cutter Grinding

Data Processing

Electronics Assembly

Machine Shop

Numerical Control Machining

Office Machine Operation

Photo Composition

Printing

Quality Control Inspection

Tool and Die Making

Supportive Services

The services at the Center consist of various professional staff members who assist the individual in achieving his goal of vocational training, by providing support to each client's unique needs. The clients may attend vocational evaluation and training on a full-time basis.

Supportive services include:

Basic Education

Counseling Services

Interpreter Services

Occupational Adjustment Training

Personal Adjustment Training

Pre-Vocational Evaluation Program

Placement Services

Social Services

Tutoring Services

Cost of Services

The Anthony Rehabilitation Center for the Deaf located at the American School for the Deaf offers services to Division of Vocational Rehabilitation clients, other agencies and individuals at cost.

Other Services

Services at the center or on-the-job may include work sample tryouts on machinery, equipment and tools; job sampling requiring skills, knowledges, habits, attitudes and adjustments related to trades and employment most applicable to hiring impaired individuals (6).

MODEL K

Massachusetts Mental Health Center
74 Fenwood Road
Boston, Massachusetts 02115

Massachusetts Mental Health Center, a State mental health center, is an intensive treatment, teaching, and research institution, and part of the teaching hospital group of the Harvard Medical School. It serves a population of 210,000 persons (Brookline, Brighton, Allston, part of Jamaica Plain, part of Back Bay Boston and part of Roxbury), plus selected cases from other areas of the State.

Inpatients

Approximately 220 patient places: Day Hospital, 55; day care and inpatient on services 1, 2, and 3, 155; children on Ward Six, 11; admissions per month, discharges per month: 80. Patients treated per month: 236.

Day Hospital

Hours 9-3:30, Monday through Friday, Census: up to 55. Several of these patients come directly from the community, others are referred from other hospitals and outside physicians. Both male and female patients are accepted, excluding severe suicidal risks. Drugs, group and individual psychotherapy are available.

Southard Clinic

The outpatient department for adults through the Walk-In-Service provides initial consultation with 300 new patients each month, emphasizing prompt attention to each patient's presenting problem. A doctor is available 24 hours a day. Further diagnostic studies, including social service work and psychological consultation, are provided where indicated. Ten-twenty percent (10-20%) of the new patients each month are admitted. All outpatient treatment, including that of patients discharged from the inpatient services, is conducted within the clinic.

Children's Unit and Clinic

The children's ward, operated through this unit and used for intensive diagnostic study and research, functions Monday - Friday; the children going to their homes for weekends and holidays. The clinic sees approximately 395 children and parents each month. The staff consists of 12 psychiatrists, 2 psychologists and 5 social workers, plus a pediatrician from the Massachusetts General Hospital. About 72 children, plus the parents, visit the clinic each month. This constitutes a total of 900 patient visits per month.

Resident Psychiatric Staff

First-year residents, 24; Second-year, 25; Third-year, 13; Fourth-year, 5.

Senior Staff

More than 50 full and part-time psychiatrists make up the teaching and supervising staff.

Nursing Service

Permanent staff includes Director of Nurses, 2 Assistant Directors, Chief Nurse, 4 supervisors, 2 instructors and 26 head nurses. There is a total of 55 attendants, including 11 LPN's and charge attendants, affiliated with the Boston College School of Nursing and McGill University School of Nursing.

Occupational Therapy Department

The staff is made up of a director, 4 registered occupational therapists, 5 occupational therapy aides, and 3 recreational therapists. Therapists work with patients in open and closed groups on each service as well as individually. Occupational therapy students from colleges all over the country spend a three-month affiliation here. The O.T. Department coordinates the hospital work therapy program for patients. The occupational therapist's unique contribution to the psychiatric team is her skilled use of activities with the patients to promote healthier modes of coping with interpersonal relationships and other life tasks.

Recreation

Staff number: 2 part-time recreational therapists, 1 full-time gym attendant and a full-time life guard. This staff works together with patients to develop a program of activities which take place both in the hospital itself and in the outside community. Volunteers are also used.

Social Service Department

Thirty-eight social workers, ten student social workers and one volunteer participate in four separate units (Inpatient and Day Hospital, Southard Clinic, Children's Unit, and Community Mental Health Services) in a variety of ways: Service (primarily) to patients and/or relatives, consultation, teaching, administration and planning research. The students come from four schools of social work: Boston College, Boston University, Simmons College and Smith College.

Rehabilitation Services

These are a joint responsibility of the Occupational Therapy Department, Rehabilitation Counselor Internship Program, and the Massachusetts Rehabilitation Commission. Evaluation, counseling, job training and, for selected clients, the service of the Commission is provided.

Psychology Department

The main functions of the department, whose staff totals 8 psychologists and 2 assistant psychologists, include diagnostic testing, individual and group psychotherapy and research. Five to six advanced graduate students in clinical psychology participate in a one-year, full-time internship training program supported primarily by the National Institute of Mental Health.

Volunteer Department

The Director of Volunteers interviews, selects, places, and meets weekly with approximately 100 volunteers per year in almost all of the hospital departments, coordinates the High School Mental Health Careers Program, handles much of the center's public relations work, and conducts tours. The majority of our volunteers are students from nearby colleges and high schools.

Research Department

There are approximately 25 ongoing research projects with a total staff of about 200 full-time and part-time researchers. The studies range from neurochemical to socio-psychological research.

Auxiliary

The nation's oldest continuously existing auxiliary to a mental hospital. The group works to benefit hospital, patients, and staff by providing service projects and funds not otherwise available: instruction and educational materials; special equipment; occupational therapy and recreation activities; social service funds for needy patients; hospitality; and initial support for promising new projects. The Auxiliary manages the coffee and gift shops to provide pleasant and convenient facilities, as well as rehabilitation opportunities for patients. The profit from these undertakings goes directly into patient services. Led by a board of 30 members, the organization also seeks to inform others about the hospital and mental health through its publications and public education programs.

Community Mental Health Service

The Community Mental Health Service was established to extend the services of the Massachusetts Mental Health Center beyond its own walls. The focus of this service is to assist in the planning, developing, coordinating and delivering of comprehensive mental health care for our catchment area. The service provides consultation, education, and training to community agencies (for example, anti-poverty agencies, Department of Welfare, schools, Model Cities) groups (mental health associations, tenant's councils, local self-help and community action groups, etc.) and individuals. In each neighborhood, we join with other social and health agencies to form inter-agency councils.

In addition, the community program provides direct service, at present focused upon crisis-intervention, home visiting and geriatric care. Finally, the community service has established liaison with a number of agencies and groups who can be of direct help to the mental health center and its patients: Visiting Nurse Association, local hospitals and health centers, employment programs, etc. Geriatric Unit--three full-time and several part-time staff members provide direct services, consultation and education to senior citizens in the catchment area, professional and non-professional care-givers, and agencies concerned with the care of the elderly. It is the most comprehensive, community focused program in the United States (8).

References

1. "Adult Vocational Program," San Francisco Aid Retarded Children, Inc., 1971-1972

2. Cohen, Lucy; Deasy, Leila; El Hehiawy, Nancy and Polivka, Jirine, (editors), Patients In Programs. Department of Human Resources, Washington, D.C., 1971

3. "Centergram," Vol. 1, No. 2, The Easter Seal Society for Crippled Children and Adults of Alameda County, Oakland, Calif., Winter, 1969-70

4. Cull, John G. and Hardy, Richard E. Vocational Rehabilitation Profession and Process. Springfield, Ill.: Charles C. Thomas Co., 1972

5. "Disabled?" Division of Vocational Rehabilitation, Connecticut State Department of Education, Hartford, Connecticut

6. "Graham H. Anthony Vocational Rehabilitation Center," American School for the Deaf, West Hartford, Connecticut

7. "Las Palmas School for Girls," Los Angeles, Calif., 1970-71

8. "Massachusetts Mental Health Center," Massachusetts Mental Health Center, Mass. Dept. of Mental Health, Boston, Mass.

9. "National Directory of Rehabilitation Facilities 1971," Region VIII, Colorado, Montana, North Dakota, South Dakota, Utah and Wyoming, U.S. Dept. of Health, Education, and Welfare, Rehabilitation Services Administration, Div. of Rehabilitation Facilities, Washington, D.C.

10. "National Urban League, Inc. OJT," National Urban League, New York, N.Y.

11. "News," U.S. Department of Health, Education, and Welfare, Washington, D.C.

12. "Pennsylvania Rehabilitation Center," Pennsylvania Bureau of Rehabilitation, Johnstown, Pa.

13. Peters, James S. Introduction to Vocational Rehabilitation. New York: American Press, Inc., 1969

14. "The Gaylord Hospital," Gaylord Rehabilitation Hospital, Wallingford, Conn.

References (continued)

15. "The Regional Rehabilitation-For-Work Center," Morgan Memorial, Inc., Goodwill, Inc., Boston, Mass.

16. "Tower System," Institute for the Crippled and Disabled, New York, N.Y.

PART IV

Discussion and Conclusion

PART IV - DISCUSSION AND CONCLUSION

It is apparent from a study such as our's that vocational rehabilitation in the United States and Western Europe is so complex and broad that it demands maximum utilization of all available community resources. We have observed advances in technology, as well as technique, in work with the mildly and the severely handicapped in the United States and all of the fifteen (15) countries and rehabilitation facilities visited. Agencies, both public and private, are active in the establishment of a consortium of services that appears to meet the needs of handicapped people, but in every instance there is still much more to be done. A universal appeal is for more and better rehabilitation facilities, workshops, trained personnel and volunteers; and, of course, money.

From our visitations we were able to see vocational rehabilitation programs in Europe that bore little or no resemblance to our State-Federal program in the United States of America in structure. However, it is obvious that a handicapped or disadvantaged person in need of rehabilitation services is not allowed to "fall through the cracks" of rejection, waiting, appealing, denial, etc. The, seemingly, humanitarian approach to human services in Europe enables government and private agency personnel to plan and foster a program of vocational and other rehabilitation services that are designed to bring immediate relief to the person and members of his family. For example, if a person is diseased or injured and applies for rehabilitation services, either he or she ends up with something after evaluation. This "something" may take the form of vocational training, welfare, social security, workmen's compensation, etc., without the person having to go through several agencies over a protracted period of time. Rehabilitation and other services are considered to be rights which the citizenry should enjoy. The "one stop" idea or philosophy is mechanism, if employed carefully, for enabling the individual to maintain dignity and awareness of the possibility that society cares.

A communality of vocational rehabilitation on both sides of the ocean is that of bringing about, for the handicapped person, a smooth and appropriate integration into the world of work and adjustment or readjustment to society. Through research and development more simplified work methods are available in industry and workshops for the handicapped. This is also true of access to places of worship, amusement, recreation, etc. in society. The various organizations responsible for rehabilitation have developed and improved their efforts to achieve suitable and effective rehabilitation for clients by taking full advantage of opportunities provided by public and private places of training and employment. It is worthwhile to note that medical, employment, rehabilitation, educational, psychological and other specialists are recognizable members of the rehabilitation team. Many of these specialists, as well as volunteers, are members of or contributors to, the following organizations engaged in International Rehabilitation:

United Nations
International Labor Organization
Pan American Health Organization
United Nations Children's Fund
World Health Organization
Agency for International Development

Bureau of International Cultural Relations,
Department of State

American Foundation for Overseas Blind, Inc.

Boy Scout World Bureau

Catholic International Union for Social Service

Cooperative for American Relief Everywhere, Inc.

International Association of Rehabilitation
Facilities

International Committee of the Red Cross

International Confederation of Free Trade Unions

International Conference of Social Work

International Council of Nurses

International Federation of Disabled Workers and
Civilian Handicapped

International Federation of Physical Medicine

International Hospital Federation

International Society for Rehabilitation of the
Disabled

International Association of Psychologists

International Union against Tuberculosis

League of Red Cross Societies

World Association of Girl Guides and Girl Scouts

World Conference for Physical Therapy

World Council for the Welfare of the Blind

World Federation for Mental Health

World Federation of the Deaf

World Federation of Occupational Therapists

World Organization for Rehabilitation through
Training Union

World Rehabilitation Fund, Inc.

World Veterans Federation

PART V

Recommendations

PART V - RECOMMENDATIONS

Introduction

In our investigation of the Vocational Rehabilitation delivery system of fourteen Western European Countries and Yugoslavia we found varying degrees of similarities and differences. There is little or no uniformity, with the possible exception of a deep concern for the disabled and disadvantaged. In discussing this concern with many government officials and functionaries of public and private agencies we were informed that vocational rehabilitation was a right of the people that the country concerned had to recognize. Vocational rehabilitation, like health, social security, workmen's compensation, education, etc., is, potentially, welfare, available for all who are in need and who can profit therefrom. In every country visited this was the prevailing principle enacted by law and statute. Undergirding the law and statute, so it seems, is a humanitarian philosophy of service to people in order to foster independent living and avoid dependency.

It was quite evident that vocational rehabilitation is a Federal government responsibility. Private efforts are encouraged, and in many instances the private health and charity organizations play a leadership role in the development of new programs and provide for their funding. But in the final analysis, it is the Federal government that furnishes the muscles which, frequently in partnership with the private sector, enables handicapped and disadvantaged citizens to receive vocational rehabilitation through the various services and facilities available.

In the United States we have the Federal government in partnership with the states fostering vocational rehabilitation services in a more structured manner, it appears, than in the European countries we visited. Other public and private health, welfare, labor, educational, and industrial organizations work very closely with the state operations and the results are similar to those found in Europe. It seems that among our professional and volunteer workers the aims and objectives are the same, i.e., helping the handicapped become more independent in our society. But, still, a basic problem here in the United States is making rehabilitation services available to all of those in need and who could, therefore, benefit from these services.

It is a recognizable fact that compared with the European countries visited, the United States is monstrous in size and population, as well as diverse in its people and customs. We must also be reminded of the fact that institutional, religious, and racial prejudice has frustrated past efforts to extend vocational rehabilitation services, as well as other humanitarian services; to the poor, blacks, and other minorities. Then, too, our country and its civilian population was not harmed directly by two World Wars. This, in and of itself, has had, it seems to us, an enlightening effect upon the people of Europe and their national government. Perhaps there is a greater appreciation of the needs of the handicapped for it is closer to home. Rehabilitation workshops and facilities are pointed to with pride, and the government gives financial support, etc. to many of them. Industry is expected to, and does, work closely with the government in training and providing employment on a full- or part-time basis for the handicapped. In Europe this relationship is mandated, in the United States it is permissive.

Because of the limited time spent in each country and the, by necessity, superficial observation of workshops and rehabilitation centers and their impact on vocational rehabilitation efforts in the United States and in Europe, our recommendations are few but pervasive. They are the following:

1. Develop a vocational rehabilitation program where the Federal government will be responsible for its delivery system. The states could be reimbursed 90 to 100% of cost. Through this type of organization, all handicapped individuals, potentially, could be served.
2. Increase the client service capacity of the state vocational rehabilitation agencies by allowing all counseling, consulting, coordinating, etc. efforts to receive credit, as well as the number of rehabilitants (number placed in productive employment).
3. Make funds available in the form of grants to all certified rehabilitation centers and workshops that are providing services to the handicapped in the United States.
4. Appropriate funds for building of rehabilitation workshops and facilities on a non-matching basis, similar to methods used by Department of Housing and Redevelopment but without the repayment feature.

5. Amend the Vocational Rehabilitation Act so that the socially and culturally disadvantaged are eligible for vocational rehabilitation services on a par with the disabled. This would make the funding of Section 15 of the Act unnecessary.

6. Establish labor laws so that business and industry have to employ a percentage of handicapped and/or disadvantaged workers. The same should apply to local, state and national government.

7. Develop a "one-door" or "one-way" system for the handicapped person to use. This would enable the handicapped person to obtain help or relief after a single trip to an agency. Rehabilitation is the job of everybody and every agency.

8. Provide more funds for international fellowships and exchange of workers in the rehabilitation field at home and abroad. This would be a plus for international goodwill on a par with the Peace Corps and The Marshall Plan.

9. Develop a program for faster international and intercontinental communication handling and translation of rehabilitation publications and other works. This is a wide gap in the rehabilitation program.

PART VI

Addendum

Public Law 93-112 of the 93rd Congress, H. R. 8070, September 26, 1973

An Act. To replace the Vocational Rehabilitation Act, to extend and revise the authorization of grants to States for vocational rehabilitation services, with special emphasis on services to those with the most severe handicaps, to expand special Federal responsibilities and research and training programs with respect to handicapped individuals, to establish special responsibilities in the Secretary of Health, Education, and Welfare for coordination of all programs with respect to handicapped individuals within the Department of Health, Education, and Welfare, and for other purposes.

Sec. 2. The purpose of this Act is to provide a statutory basis for the Rehabilitation Services Administration, and to authorize programs to--

(1) develop and implement comprehensive and continuing State plans for meeting the current and future needs for providing vocational rehabilitation services to handicapped individuals and to provide such services for the benefit of such individuals, serving first those with the most severe handicaps, so that they may prepare for and engage in gainful employment;

(2) evaluate the rehabilitation potential of handicapped individuals;

(3) conduct a study to develop methods of providing rehabilitation services to meet the current and future needs of handicapped individuals for whom a vocational goal is not possible or feasible so that they may improve their ability to live with greater independence and self-sufficiency;

(4) assist in the construction and improvement of rehabilitation facilities;

(5) develop new and innovative methods of applying the most advanced medical technology, scientific achievement, and psychological and social knowledge to solve rehabilitation problems and develop new and innovative methods of providing rehabilitation services to handicapped individuals through research, special projects and demonstrations;

(6) initiate and expand services to groups of handicapped individuals (including those who are homebound or institutionalized) who have been underserved in the past;

(7) conduct various studies and experiments to focus on long neglected problem areas;

(8) promote and expand employment opportunities in the public and private sectors for handicapped individuals and to place such individuals in employment;

(9) establish client assistance pilot projects;

(10) provide assistance for the purpose of increasing the number of rehabilitation personnel and increasing their skills through training; and

(11) evaluate existing approaches to architectural and transportation barriers confronting handicapped individuals, develop new such approaches, enforce statutory and regulatory standards and requirements regarding barrier-free construction of public facilities and study and develop solutions to existing architectural and transportation barriers impeding handicapped individuals.

Federal Register, Tuesday, June 11, 1974, Washington, D.C.
Volume 39, Number 113, Part II

DEPARTMENT OF LABOR
Employment Standards Administration

EMPLOYMENT OF THE HANDICAPPED

Affirmative Action Obligations of Contractors and Subcontractors

PART 741---AFFIRMATIVE ACTION OBLIGATIONS OF CONTRACTORS AND SUBCONTRACTORS

On September 26, 1973, the President signed the Rehabilitation Act, Public Law 92-112, which, among other things, requires Government contractors and subcontractors to take affirmative action to employ and advance in employment qualified handicapped individuals. By virtue of authority delegated to me by Executive Order No. 11758, and pursuant to section 503 of the Rehabilitation Act, I hereby issue Title 20, Chapter VI Subchapter C, Part 741 of the Code of Federal Regulations, setting forth the duties of contractors, subcontractors and agencies.

Subpart A---Preliminary Matters, Affirmative Action Clause, Compliance

§ 741.1 Purpose and application.

The purpose of the regulations in this part is to assure compliance with section 503 of the Rehabilitation Act of 1973, which requires government contractors and subcontractors to take affirmative action to employ and advance in employment qualified handicapped individuals. The regulations in this part apply to all government contracts for personal property or nonpersonal services (including construction) in excess of $2,500. Failure of a contractor to comply with any provision of the regulations in this part shall be grounds for the imposition of any or all of the sanctions authorized herein. The regulations in this part do not apply to any action taken to effect compliance with respect to employment or participation in Federal grant programs under section 504 of the Rehabilitation Act of 1973.

State of Connecticut

PUBLIC ACT NO. 73-279

AN ACT CONCERNING THE RIGHTS OF THE BLIND AND OTHERWISE PHYSICALLY DISABLED

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. For purposes of this act, an individual is blind if his central visual acuity does not exceed 20/200 in the better eye with correcting lenses, or if his visual acuity is greater than 20/200 but is accompanied by a limitation in the fields of vision such that the widest diameter of the visual field subtends an angle no greater than twenty degrees.

Section 2. The physically disabled, including, but not limited to, the blind shall be entitled to full and free use of streets, highways, sidewalks, and any mode of public transportation, subject only to the conditions and limitations established by law and applicable alike to all persons. Any person who violates any provision of this section shall be guilty of a class C misdemeanor.

Section 3. Section 22-346a of the 1969 supplement to the general statutes is repealed and the following is substituted in lieu thereof: (a) Any blind person may travel on a train or on any other mode of public transportation, and may enter any other place of public accommodation WHICH CATERS OR OFFERS ITS SERVICES OR FACILITIES OF GOODS TO THE GENERAL PUBLIC, including BUT NOT LIMITED TO, any public building, inn, restaurant, hotel, motel, tourist cabin, place of amusement, resort or any facility of any such public accommodation, accompanied by his guide dog, and he may keep such guide dog with him at all times in any such public accommodation or facility thereof at no extra charge, provided such dog shall be in the direct custody of such blind person [,] AND shall be wearing a harness [and shall be properly muzzled; and provided such blind person shall have in his possession a credential issued by an accredited school for dog training. (b) Upon request of any person in charge of any such public accommodation or upon request of any employee thereof, such blind person shall present such credential for inspection].

TITLE 45---PUBLIC WELFARE

CHAPTER IV---SOCIAL AND REHABILITATION SERVICE (REHABILITATION PROGRAMS), DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

PART 401---THE STATE VOCATIONAL REHABILITATION PROGRAM

Supplemental Security Income Recipients

Notice of proposed regulations to revise Chapter IV of Title 45 of the Code of Federal Regulations in order to implement section 1615 of the Social Security Act with respect to the provision of vocational rehabilitation services to certain supplemental security income recipients was published in the FEDERAL REGISTER on February 11, 1974 (39 F.R. 5248).

Subpart E---Vocational Rehabilitation Services for Supplemental Security Income Recipients

§ 401.120 General.

(a) Section 1615 of the Social Security Act provides for the referral of blind or disabled supplemental security income recipients who are under age 65 to the appropriate State agency administering the State plan for vocational rehabilitation services approved under the Rehabilitation Act of 1973 and for a periodic review of their need for and utilization of available vocational rehabilitation services. Individuals so referred must accept such vocational rehabilitation services as are made available, unless there is good cause to refuse. Authorization is provided to pay the State agency the costs incurred in the provision of such services to individuals so referred.

(b) Funds appropriated under this authority will be made available for payment by the Secretary for vocational rehabilitation services (and related costs of administration) provided under the State plan approved under the Rehabilitation Act of 1973.

(c) To receive Federal funds for services under this subpart, each State agency is required to submit an amendment to its State plan which sets forth the policies and procedures for providing services to blind and disabled recipients in keeping with the purpose as stated below and which meets the requirements and conditions prescribed herein.

§ 401.121 Purpose.

The purpose of the provision of vocational rehabilitation services as authorized in this subpart is to enable a maximum number of recipients to increase their employment capacity to the extent that they can engage in productive activity.

§ 401.122 Applicability of other regulations.

The provisions governing vocational rehabilitation services to supplemental security income recipients, the costs of which are paid from supplemental security income program funds, must conform to all requirements elsewhere in this part governing the State vocational rehabilitation programs which are not inconsistent with the requirements prescribed in this subpart.

§ 401.123 Definitions.

(a) "Supplemental security income recipient", or "recipient", as used in this subpart, means an individual who is receiving cash payments (or with respect to whom payments are made) under the supplemental security income program based on blindness or disability.

(b) "Productive activity" means full-time employment, part-time employment, or self-employment wherein the nature of the work activity performed, the earnings received, or both, or the capacity to engage in such employment or self-employment, can reasonably be expected to result in termination of eligibility for supplemental security income payments, or at least a substantial reduction of such payments in accord with income exclusions applying to the blind as specified in 20 CFR Part 416, Subpart K.

Public Law 93-516 of the 93rd Congress, H. R. 17503, December 7, 1974

An Act. To extend the authorizations of appropriations in the rehabilitation Act of 1973 for one year, to transfer the Rehabilitation Services Administration to the Office of the Secretary of Health, Education, and Welfare, to make certain technical and clarifying amendments, and for other purposes; to amend the Randolph-Sheppard Act for the blind; to strengthen the program authorized thereunder; and to provide for the convening of a White House Conference on Handicapped Individuals.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

TITLE I---AMENDMENTS TO THE REHABILITATION ACT OF 1973

Short Title

Sec. 100. This title shall be known as the "Rehabilitation Act Amendments of 1974".

Rehabilitation Services Administration

Sec. 101. (a) Section 3(a) of the Rehabilitation Act of 1973 is amended to read as follows:

"(a) There is established in the Office of the Secretary a Rehabilitation Services Administration which shall be headed by a Commissioner (hereinafter in this Act referred to as the 'Commissioner') appointed by the President by and with the advice and consent of the Senate. Except for titles IV and V and as otherwise specifically provided in this Act, such Administration shall be the principal agency, and the Commissioner shall be the principal officer, of such Department for carrying out this Act. In the performance of his functions, the Commissioner shall be directly responsible to the Secretary or to the Under

Secretary or an appropriate Assistant Secretary of such Department, as designated by the Secretary. The functions of the Commissioner shall not be delegated to any officer not directly responsible, both with respect to program operation and administration, to the Commissioner."

(b) The amendment made by subsection (a) of this section shall be effective sixty days after the date of enactment of this Act.